City Road Medical Centre

Quality Report

City Road Medical Centre
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services effective?	Good
Are services responsive to people's needs?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the practice on 14 March 2016 where breaches of legal requirements were found. After the inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this desk-based focussed inspection on 13 September 2016 to check that the practice had followed their plan to confirm that they now met the legal requirements. This report covers our findings in relation to those requirements and also where additional improvements have been made following the initial inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for City Road Medical Centre on our website at www.cqc.org.uk.

Overall the practice is rated as Good. Specifically, following the focussed inspection we found the practice to be good for providing effective and responsive services.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

• The practice offered proactive, personalised care to meet the needs of the older people in its population. One of the GP Partners was a GP with a Special Interest (GPwSI) in Geriatrics. Needs assessments were carried out in patient's homes or at a local hospital. Personalised, long term plans for treatment, rehabilitation and support were formulated.

• The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

• Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, 100% of patients with the heart condition atrial fibrillation were treated with the appropriate anti blood clotting drugs.

• The practice provided services for older people such as an on-site podiatrist, shingles and flu vaccination. Feedback from the PPG was that these services were well publicised and well run.

• All patients aged over 75 had a named GP. Routine over 75 health checks were carried out and patients of concern were discussed at monthly primary health care team meetings.

People with long term conditions

Good

The practice is rated as good for the people with long-term conditions.

• The nurse led in chronic disease management. Patients at risk of hospital admission were identified as a priority.

• The practice was proactive in managing patients with long term conditions through new local initiatives. Dedicated appointments and longer consultation times were available when needed.

• Performance for diabetes related indicators were between 68% and 98%. This was in line with the CCG and national average range of 78% to 94%.

• All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

• The practice supported patients with information about self-care techniques with online resources, referral to expert patient programmes and health navigators.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

• There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young of concern were discussed at monthly children's multi disciplinary team (MDT) teleconferences.

• Immunisation rates were relatively high for all standard childhood immunisations.

• The practice was involved in a training and accreditation programme aimed at increasing accessibility for young people.

• The practice website had a dedicated youth page which advertised suitable services and provided general advice.

• Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

• The practice's uptake for the cervical screening programme was 83% which was in line with the national average of 82%.

• Appointments were available outside of school hours and the premises were suitable for children and babies. Children were always prioritised for appointments.

• There were positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

• The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

• Appointments were available until 7.30pm on Mondays and Thursdays and every other Saturday morning to support working age people to access the practice.

Summary of findings

• The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Text reminders for appointments were sent to patients.

• Health promotion and screening appointments were available. For example targeted health checks were offered to patients aged between 35 and 75 years or patients identified with a high risk of having a heart attack or stroke over the next ten years.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

• The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.

• The practice offered longer appointments for patients with a learning disability. These patients were invited for annual health checks.

• The practice worked collaboratively with local supported housing facilities, including those for people with drug and alcohol dependency and YMCAs.

• The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Local homeless shelters and other local services were represented at primary health care team meetings. Patients were signposted to other appropriate local services.

• Weekly drug and alcohol community services clinics were held on site.

• Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Staff had received training around domestic violence and identification of female genital mutilation at clinical meetings.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

• 95% of patients experiencing poor mental health had a comprehensive agreed care plan in the last 12 months. This was above the national average of 88%.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- Patients were referred to various support groups and voluntary organisations services such as iCope psychological therapies service.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

City Road Medical Centre

Detailed findings

Why we carried out this inspection

We undertook a desk-based focussed inspection of City Road Medical Centre on 13 September 2016. This is because the service had been identified as not meeting some of the legal requirements and regulations associated with the Health and Social Care Act 2008.

From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically breaches of Regulations 9 (Person centred care) and 18 (Staffing)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

At the comprehensive inspection carried out on 14 March 2016 we found the procedures in place for ensuring the care and treatment of patients was appropriate and met their needs and ensuring persons they employed received such appropriate supervision and appraisal as was necessary required improvement. Patient satisfaction with the practice's opening hours and telephone access as well as access to their preferred GP required improvement.

This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 14 March 2016 had been made. We inspected the practice against two of the five questions we ask about services; is the service effective and is the service responsive?

Good

Are services effective?

(for example, treatment is effective)

Our findings

When we inspected the practice on 14 March 2016 we found the practice's exception reporting rate was 13%.(Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This was higher than the CCG average of 10% and the national average of 9%. This meant a significant proportion of patients were at risk of not receiving the appropriate levels of care and treatment.

The practice's level of exception reporting for mental health of 29% was higher than the CCG and national averages of 11%. Exception coding for asthma at 27% was higher than the CCG and national averages of 4.6% and 6.8%. At the time of the inspection the practice was aware of this variation in relation to mental health. However, the practice was unaware of the level of exception reporting for asthma.

Following the last inspection the practice provided us with an action plan to describe the action they were going to take to meet the regulation and what they intended to achieve. They also provided us with a further update prior to this inspection. In relation to asthma, evidence we received showed the practice had introduced a system whereby if a patient did not respond to two letters/phone invites for reviews, their named GP would call then them to encourage them to attend. If they still did not attend, they would not be exception reported until the end of the QOF year (end of March every year) in case the practice could opportunistically review their long-term condition during other consultations.

The practice had also started to use a system called Patient Chase which involved inviting patients for one long-term condition review and adjusting the length of this appointment according to the number of long-term conditions they had, rather than inviting them for multiple reviews. It was hoped that by reducing the number of invitations patients received, this may increase patient engagement and minimise exception reporting. Evidence we were provided with following the inspection showed that the results for QOF year 2015/16 for asthma, the practice's rate of exception reporting had reduced to 8% from 27% in 2014/15. (At the time of writing, the QOF results for 2015/16 were unpublished).

The practice had introduced a number of measures to address the level of exception reporting for mental health. These included improving and strengthening collaborative working with the Primary Health Care Team (PHCT) and Primary Care Mental Health Team (PCMHT). Regular meetings took place with both teams where patients of concern were discussed and planned for. The PCMHT ran a regular clinic at the practice which had short waiting times, thus improving engagement. The practice had continued its involvement in the Integrated Networks pilot scheme. This involved GPs from three GP practices meeting on a weekly basis, together with a consultant mental health nurse, a health navigator, an integrated care matron from the local hospital, a representative from social services and a dedicated community matron. It was found that this scheme was particularly helpful at identifying patients with mental health problem who had been bypassing primary care and attending accident and emergency. During the meetings, the team developed an integrated, care planning approach that would support patients within primary care.

The practice provided evidence to demonstrate how these measures had impacted positively on patients in terms of improving engagement. Examples were given of patients who had previously been difficult to engage with attending for reviews at the practice following coordinated, multi disciplinary intervention. Results for QOF year 2015/16 for mental health showed an improvement from 29% in 2014/15 to 26% in 2015/16. (At the time of writing, the QOF results for 2015/16 were unpublished).

When we inspected the practice on 14 March 2016 we found the practice nurse had not had appraisals despite having been employed by the practice for six years. The practice nurse was a long term locum nurse provided by an agency. Non-clinical staff had not had an appraisal since 2014. These had been delayed due to the long term absence of the practice manager.

Following that inspection we were provided with evidence to demonstrate that the practice nurse had since undergone an appraisal in July 2016. All of the other remaining staff had undergone appraisals in June and July 2016, apart from two which were not due until December 2016.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Results from the national GP patient survey published on 7 January 2016 showed that patient's satisfaction with how they could access care and treatment was below local and national averages.

At the time of the last inspection the practice told us they were in the process of an ongoing quality improvement programme. We saw evidence of this during that inspection. This included the recruitment of additional administrative staff, to improve patients' telephone access. The clinicians worked on the telephone triage/consultation service at least two days a week on a rota basis. These appointments can be booked on the day or in advance, meaning that if patients had a preference of GP, they could find out when that GP would be on duty on the telephone. Patients could also request for their preferred GP to call them back and there was no limit to the number of patients who could utilise the triage/consultation service each morning. Where a face to face appointment was deemed necessary, this would be on the same day, with the same GP the patients spoke with on the telephone, thereby improving the opportunity for patients to be seen by the GP of their choice.

The latest results were published on 7 July 2016 and showed:

- 64% of patients were satisfied with the practice's opening hours (CCG average of 70%, national average of 76%).
- 70% patients said they could get through easily to the surgery by phone (CCG average 77%, national average 73%).
- 26% patients said they always or almost always see or speak to the GP they prefer (CCG average 51%, national average 59%).

Whilst these results remained below average there was evidence to demonstrate that the practice had taken positive steps to address the areas where patient satisfaction was low.