Central Medical CentreCentral Medical Centre

Quality Report

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Date of inspection visit: 14 May 2014
Date of publication: 10/10/2014

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.

Summary of findings

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Summary of findings

Overall summary

Central Medical Centre is a GP surgery in Morden. The practice was set out over two floors and had seven consulting rooms and one treatment room. The practice has been at this location for approximately 30 years. They have approximately 8500 patients on their list and there were two partners and four salaried GP's. They also have one full-time and two part time nurses. All the GP's had individual patient lists so that they can provide patient-centred treatment and ensure continuity of care. The practice is registered to carry out the regulated activities of diagnostic and screening services, family planning, midwifery and maternity and treatment of disease, disorder and injuries.

We found that the service was safe, effective, well led, caring and responsive to patient's needs. The practice had a high proportion of patients from the Tamil community (approximately 55%) and we saw that the practice responded to the needs of these patients very well. Approximately 10% of these patients had been with the practice for over 15 years and more and although some had moved out of the practice locality area the Primary Care Trust (PCT) now known as Clinical Commissioning Group (CCG) recognised the importance of continuity of care and had allowed special arrangements for the patients to continue to be registered with the practice.

Effective support and counselling services were in place to assist patients who require psychology services, including refugees who accessed the service. The practice had systems in place for the management of chronic long-term conditions such as diabetes and high blood pressure. Services were in place to support mothers and babies; this included a visiting midwifery service, immunisation programme and health visitor. Sexual health education and contraception services were available for young people. Older people had access to a range of services to maintain their health and if they had mobility issues were able to request home visits. Access arrangements were made in consideration of the working age population.

We spoke with 12 patients and received 12 completed comment cards. The feedback we received was very positive. People described the GP's and staff as friendly, helpful and caring and were confident in their assessments. The patients we spoke with during the inspection were complimentary about the practice. They felt the service provided was to an excellent standard and responsive to their needs.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice monitored significant events appropriately and held quarterly meetings to discuss them. Lessons learnt were logged and we saw evidence of changes that had been implemented as a result of learning from events. One of the GPs was the safeguarding lead and took responsibility for following up safeguarding issues. All staff had received safeguarding adults training and clinical staff had completed Level 3 child protection training. Medicines and vaccines were stored appropriately and records were maintained of the daily checks carried out to fridge temperatures. Repeat prescriptions were turned around within 48 hours. There were infection control policies and procedures in place and the provider was carrying out regular audits for infection control to ensure risks associated with infection were minimised.

Are services effective?

The GPs demonstrated how they used national and current legislation and guidance to assess patients' needs and deliver care and treatment. Due to a high south Asian population there was a high prevalence of diabetes (Diabetes UK suggests that diabetes prevalence can be up to six times more likely for the south Asian population). Staff were supported to enable them to be effective in their roles and they received appropriate training and development opportunities. We saw many examples of how the practice worked with others including midwifery, the CCG and community nurses.

Are services caring?

We spoke with 12 patients and reviewed 12 completed comment cards. Patients were complimentary of staff working in the practice. They felt staff treated them with dignity and respect. Patients told us they were involved in making decisions about their care and treatment options were explained to them. We observed that staff always knocked before entering consultation and treatment rooms; even if they knew they were supposed to be empty. Both staff and patients were aware of the chaperone policy and there were signs in reception reminding patients of the policy.

Are services responsive to people's needs?

Overall the service was responsive. The practice had a high number of people from the south Asian population, some of whom were refugees. Staff in the practice spoke 14 different languages to cross some of the language barriers for patients. There were a high number of patients with long-term conditions such as diabetes and high blood pressure. The practice had very good links with external

Summary of findings

organisations to meet the needs of their patients. This included links with local health services and cultural organisations such as the mosque and temple. We reviewed the practice complaints log and saw that complaints were handled and processed in line with practice policy.

Are services well-led?

The practice had a business development plan with a mission statement. It clearly identified the areas of the business that required development. We saw that they had involved the Patient Participation Group (PPG) and the staff when planning developments relating to the practice. There were joint working arrangements with other practices in the area and they worked well with each other to develop and improve services for patients. Staff told us they were well supported and the management lines of responsibility were clear. The practice carried out staff and patient satisfaction surveys to gain feedback and help them improve.

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
Older People received a service which was caring, responsive and safe and responded well to their needs.

People with long-term conditions
People with long term conditions received a service that was caring, responsive, effective and safe. The practice organised and arranged care in line with patients' needs including ensuring reviews were completed.

Mothers, babies, children and young people
Mothers, babies, children and young people received a service that was caring, responsive and effective. The practice had processes in place to protect babies health needs and promote healthy development.

The working-age population and those recently retired
The service responded well to the needs of this population group. Health checks were available for the over 50's, the practice opening hours were reflective of the needs of working people.

People in vulnerable circumstances who may have poor access to primary care
People in this population group received a service that was safe, effective and caring. Access to care appropriate and responsive.

People experiencing poor mental health
People with mental health problems received a safe, responsive, caring and effective service. Appropriate support was in place to encourage patients to stay well.

Summary of findings

What people who use the service say

We spoke with 12 patients and received 12 completed comment cards. The feedback we received was very positive. Patients described the GP's and staff as friendly, helpful and caring and were confident in their assessments. Patients we spoke with during the inspection were complimentary about the service. People felt the service provided was to an excellent standard and responsive to their needs.

Some patients commented that it often took long to get through on the telephone, although some people told us things had improved since the implementation of the new phone system. Generally people were happy with the availability of (booked and emergency) appointments. Parents we spoke with were pleased that children were prioritised and usually given appointments on the same day.

People with long term conditions confirmed that they had regular reviews and all the patients we spoke with said that repeat prescriptions were always available within 48 hours.

Areas for improvement

Action the service COULD take to improve

- The practice told us that nine per cent of their patients had diabetes, which they said was high for a practice to have. Due to the number of patients who are diabetic the provider could consider introducing insulin conversion clinics to provide a more accessible service for patients who need to convert from medication to injections.
- Make use of the tools available to keep records of the cleaning carried out in the practice so that they can be assured what areas are being cleaned and how frequently. For example the schedules kept did not indicate whether chairs or fixed seating had been cleaned.
- The practice could consider implementing more robust systems, to ensure staff are regularly and continually updated and involved in the service activities.

Good practice

Our inspection team highlighted the following areas of good practice:

- The practice offers annual health checks to all teenagers to ensure they maintain healthy lifestyles.
- Leaflets on various health conditions and health promotion literature are available in a variety of languages and in accessible formats to benefit patients with learning disabilities. This included a leaflet for breast cancer screening which was available in easy read format.
- The practice has good links with the local temple to meet patients cultural and spiritual needs
- The practice maintains close checks on children who have received immunisations and remind parents when they are overdue. They also have a system in place to contact embassies when children are from abroad did not have any immunisation history. They would contact the embassy to find out the standard immunisations they should have received in their country of origin.

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Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC Lead Inspector. The inspector was accompanied by two specialist advisors (a GP and Practice Manager).

Background to Central Medical Centre

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Central Medical Centre is a GP surgery in Morden. The practice is set out over two floors and has seven consulting rooms and one treatment room. The building has been modified, having previously been in commercial use. The practice has approximately 8500 patients on their list; there were two partners and four salaried GPs, one full-time and two part time nurses. All the GPs have individual patient lists so that they can provide person- centred treatment and ensure continuity of care.

The practice has a diverse patient demography including a high proportion of patients from the Tamil community (approximately 55 per cent). Some of the patients do not live in the locality area any more, however due to the positive outcomes and the desire to maintain continuity of care arrangements are in place with the CCG to allow patients who have moved out of the area to remain with the practice.

The Merton Joint Strategic Needs Assessment (JSNA) highlighted Lower Morden (the area the practice is in) as being in a part of the borough where they have a higher than average number of people with excess weight. Staff told us approximately 5 percent of the patient population had excess weight.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. The provider was randomly selected.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

Detailed findings

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Prior to the inspection we analysed information relating to the practice from the CQC intelligent monitoring and other sources including the Office for National Statistics, Public Health England and the GP National Survey results. We also contacted and spoke with a number of key stakeholders, including NHS England, Merton Clinical Commissioning Group and Healthwatch Merton to gather local intelligence and give them an opportunity to provide feedback about the service.

During our visit we spoke with a range of staff including GPs, nurses, administration staff and the practice manager. We also spoke with patients who used the service. We observed how patients were being cared for and talked with carers and/or family members and reviewed the practice's policies, procedures and audits. We reviewed comment cards and NHS Choices website where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

The practice monitored significant events appropriately and held quarterly meetings to discuss them. Lessons learnt were logged and we saw evidence of changes that had been implemented as a result of learning from events. One of the GPs was the safeguarding lead and took responsibility for following up safeguarding issues. All staff had received safeguarding adults training and clinical staff had completed Level 3 child protection training. Medicines and vaccines were stored appropriately and records were maintained of the daily checks carried out to fridge temperature. Repeat prescriptions were turned around within 48 hours. All staff had received recent training for infection control.

Our findings

Safe patient care

There were mechanisms in place to ensure patients received safe care. For example, the practice recorded non-attendance to reviews of long term conditions. If a patient did not attend a review then their repeat prescription would not be processed which meant they had to attend the practice for their review before further medication was prescribed. Staff told us the practice sent continual reminders if people persistently failed to attend their review.

Incidents and complaints were investigated and improvements were made where necessary. Any learning outcomes were disseminated to all staff.

Learning from incidents

The practice monitored significant events. Quarterly meetings were held and attended by all the clinicians in the practice. The notes from these meetings were documented with details of the event recorded, who was involved, the impact on patients, how it was resolved and lessons learnt. The template for the meeting had been updated recently and we saw that the changes had improved the monitoring of significant events. Staff gave us examples of significant events that had occurred, for example we the practice changed the way they triaged children when they attended the practice for appointments. The lessons learnt from the event were shared with staff in the practice and safety standards were improved as a result of the handling of the event.

Safeguarding

One of the GPs was the assigned safeguarding lead for the practice. All the GPs and nurses had completed Level 3 child protection training and were aware of the recommendation to update training on a three year cycle. We saw that all clinical staff had completed this training within the last three years. All staff had completed vulnerable adults training. Staff we spoke with demonstrated an awareness of safeguarding. They were able to describe what signs they would look out for with potential and actual abuse.

The practice had a safeguarding vulnerable adults and child protection policy and procedure. Staff were aware of the policy and were able to describe what they would do if

Are services safe?

they needed to report safeguarding. Their explanations were in line with their policy and indicated that in the event of a safeguarding situation they would be prepared to respond to ensure patients safety.

Monitoring safety and responding to risk

All staff had received medical emergencies and cardiopulmonary resuscitation (CPR) training. We were given an example of an event where staff had to respond to a situation when a patient had a bad reaction to an immunisation. Staff had followed the emergency procedure to ensure the patients safety. We saw that the patient's details were updated following the incident so that staff could monitor the safety of the patient and ensure they would be prepared to respond in the event of a similar incident.

There were emergency medicines and equipment to deal with medical emergencies including a defibrillator, oxygen and anaphylaxis for adults and children. The practice maintained regular checks to ensure the equipment was working and drugs were in date.

There was a staff rota in place to ensure that staff were able to respond to busy periods. Some of the reception staff worked part-time but they explained that they regularly covered colleague's shifts to ensure there was a full complement of staff to meet the needs of patients and run an efficient service.

Medicines management

There were procedures in place for the effective storage and disposal of medication and vaccines. Medication and vaccines were stored in fridges in the two treatment rooms. Each fridge had a thermometer and they were both secured with locks to prevent unauthorised access. Appropriate daily checks were carried out to measure the fridge temperatures and records of these checks were maintained. We saw that the fridge temperatures were always between the minimum and maximum temperatures of 2ºC and 8ºC. However the provider was not following Public health England guidance for storing vaccines. The guidance recommends that all fridges should have two thermometers one that is independent of mains power. Medication was disposed of via the pharmacist. No medication was collected from patients, instead they were asked to dispose of all unused medication via the pharmacy.

No controlled drugs were kept on the premises. GPs told us that they did not routinely carry emergency drugs in their bags, however if they were going on a visit that may require the administration of emergency drugs they would take them from the emergency kit. A log would be made of what they had taken and who had taken it.

There were reliable systems in place to ensure safe repeat prescribing for patients. There was a comprehensive repeat prescribing protocol which helped to minimise the risk of medication errors. Requests could only be made via post, pharmacy or hand delivered paper copies. Telephone requests were not accepted because there was the potential for error. Prescriptions were checked against the date of last issue and quantity. The prescriptions were then passed to a GP to be checked and signed. If there were requests for items not on the list then prescriptions were only issued by a GP or nurse practitioner. The practice had recently employed an in-house pharmacist who worked 3 hours a week. The pharmacists' role was to check prescribing and carry out audits on prescribing.

Cleanliness and infection control

The practice had a policy in place for infection prevention and control (IPC).

There were some areas of the treatment room that were a worn and in need of updating. We discussed this with the practice manager who agreed and said that they would make plans for the renewal of items such as the lino, which required changing. They assured us that the practice was cleaned every day by a contractor and the areas that required updating were clean. They also had monthly steam deep cleans to certain areas. The records maintained by the cleaners were inadequate. They did not record sufficiently what had been cleaned so there was no assurance of what tasks they had completed. Overall the surgery was clean on the day of our visit. We saw copies of the infection control audits that the practice had completed.

All staff in the practice had recently completed infection control training and were up to date with procedures for infection control.

Staffing and recruitment

Appropriate employment checks were carried out. We saw in some instances references were requested but not always obtained by the practice before applicant's commenced employment. Whilst there was no written

Are services safe?

recruitment policy there were policies and procedures in place for new staff including induction and training guides. All clinical staff had Disclosure and Barring checks (DBS). All new non-clinical staff also had them. There were some staff who had been working at the practice for many years (20 years and more) and DBS checks had not been carried out. The practice manager explained that although their character had been verified at the point of employment the DBS checking system was not in place so they could not have completed the check. They did however provide evidence that they proposed to get up to date checks for all staff that did not have them.

Dealing with Emergencies

The practice had a business continuity plan to ensure that effective services would be maintained in the event of a major incident or disruption to service. The plan outlined how they would respond to major incidents for example the total failure of mains supply to the practice, failure of IT systems or loss of medical records. Whilst the practice had not had to respond to such emergencies recently the plan evidenced that they would be prepared in the event.

Are services effective?

(for example, treatment is effective)

Summary of findings

The GPs demonstrated how they used national and current legislation and guidance to assess people's needs and deliver care and treatment. Due to a high south Asian population there was a high prevalence of diabetes (Diabetes UK suggests that diabetes prevalence can be up to six times more likely for the south Asian population). The practice had effective systems in place to manage conditions which included regular reviews and links with community teams such as diabetes specialists. Staff were supported to enable them to be effective in their roles and they received appropriate training and development opportunities. We saw many examples of how the practice worked with others including midwifery, the CCG and community nurses.

Our findings

Promoting best practice

We saw that GPs took account of best practice guidelines when planning and delivering care. We saw that GPs considered legislation and guidance such as the Mental Capacity Act 2005 and National Institute for Health and Care Excellence (NICE) guidelines. The practice held monthly clinical meetings which all clinicians attended and were updated on best practice.

Management, monitoring and improving outcomes for people

General Practice High Level Indicators 2013/14 identified the practice as an outlier for high levels of diabetes. Practice staff were aware of the data and were able to explain the reasons for it, including the demographics of the local population and how they helped patients to manage their condition. For example, the practice had close links with the community diabetic liaison team (people could be referred to the team for additional support) and regular reviews to monitor conditions. The practice demonstrated that they proactively encouraged patients through education and reminders to assist in controlling the condition as best as they could.

General Practice Outcomes Standards (GPOS) data highlighted the practice as an over prescriber of Non Steroid Anti Inflammatory Drugs (NSAID), which includes pain killers such as Ibuprofen. We looked at prescribing during the inspection and found prescribing to be in line with the population group of the practice. The doctor's explained that they had high portions of patients with long term conditions or the economically deprived. Therefore if patients required NSAID GPs gave it on prescription rather than expecting them to purchase it over the counter. They told us that providing a prescription was the most effective way to ensure the patient took the required medication. The over prescribing was therefore a positive thing because it ensured patient's safety.

The practice was doing more to improve detection of patients with an irregular heartbeat to prevent strokes (atrial fibrillation (AF)). The practice was aware of their low prevalence rates and explained that there were actions in place to increase their identification rates. This included checking the pulse rate of all new patients during new patient checks. If an irregular heartbeat was detected they

Are services effective?

(for example, treatment is effective)

were referred to the GP and had an electrocardiogram (ECG). They also carried out screening for over 65's during annual health checks. Patients living with the condition were reviewed annually.

All patients with long term conditions were reviewed every three to six months depending on the control of their condition. This included asthma, high blood pressure, cancer and mental health problems. Patients were invited to attend and their medication / care plan was reviewed if required. Health checks were carried out annually for people in these groups and meetings were held with specialists such as learning disabilities nurses, diabetic nurses and a mental health consultant to ensure conditions were managed in a safe and joint approach.

Clinical audits had been carried out to look the prescribing of medication for osteoporosis and diabetes.

Staffing

Staff had access to appropriate learning and development opportunities. All GPs and nurses had five study days per year to support their continuing professional development. The nurses were appraised by the GPs. They were also supervised regularly via weekly meetings with one of the GPs. The practice manager completed non-clinical staff appraisals. Records showed that the GP's had been appraised and had completed the revalidation process in order to maintain their professional registration. Staff we spoke with felt supported and felt that they had access to training opportunities.

Working with other services

There were systems in place to follow up on OOH calls. Service information was sent to the practice electronically and uploaded straight into the system and a GP had to acknowledge that they had read the report the following morning. The GP was responsible for any follow up required. The practice also had a form which they faxed to the OOH service to alert them if a patient was at end of life and to the possibility they may be contacted.

A midwife visited the practice every two weeks to carry out routine ante-natal checks such as blood pressure, urine tests and listen to the baby's heartbeat. The midwife liaised well with the GP's at the practice, updating them accordingly on the development of the pregnancy and also if they identified a non-pregnancy related issue.

The practice had close links with various stakeholders and agencies to ensure a co-ordinated approach to the care of their patients. One of the GP's regularly attended the Clinical Commissioning Group (CCG's) practice leads bi-monthly meetings. Annual meetings were held with the prescribing pharmacist to meet the practice objectives for prescribing. GP's also attended quarterly safeguarding and child protection meetings.

Health, promotion and prevention

There was a dedicated member of staff who carried out all the new patient health checks. This included smoking and alcohol screening. Patients were asked to bring a list of all medication they were taking and these were noted. If the member of staff felt it necessary they would triage the patient to a GP for a review of their medication or further investigation if required. The practice did not provide smoking cessation clinics, however we saw that they referred people to services which provided support. Some of the patients we spoke with confirmed that they had been referred to these services.

Effective screening systems were in place to ensure babies and children received immunisations at the right times. This included sending a letter to parents when a child was born to remind them about the immunisations that are due and contacting parents when an immunisation was overdue. There were a high number of patients who were from abroad. The practice had a system in place where they contacted the Embassies of children who did not have their immunisation history to find out what the countries standard immunisations were. This was so they could correlate the information to maintain up to date records.

The practice used to run sexual health clinics however they reviewed the effectiveness of this and realised there was a higher up take for one-to-one sessions. Patients could therefore make an appointment at any time to see a GP or nurse for sexual health advice or contraception. Leaflets were available in multiple languages and there was information on the practices website promoting the service. Since the implementation of the new system for sexual health there had been a significant reduction in termination of pregnancies.

Annual health checks were carried out and the practice had completed 100% for all patients with a learning disability in 2013. One of the GP's in the practice met with a learning disabilities specialist nurse every three months. During these meetings they discussed all patients on the learning disabilities register and explored how they could improve their lifestyle and improve health. For example the GP told

Are services effective?

(for example, treatment is effective)

us that these meetings assisted them in finding out about service they could signpost patients to such as services for people with swallowing problems. Also by going through each individual patient's case they were able to develop specific plans for patient's improvements such as increasing home support or identifying health issues. Annual health checks were also offered to all teenagers registered with the practice, This was to ensure their health was regularly monitored and maintained.

Are services caring?

Summary of findings

We spoke with 12 patients and reviewed 12 completed comment cards. Patients were complimentary of staff working in the practice. They felt staff treated them with dignity and respect. People told us they were involved in making decisions about their care and treatment options were explained to them. The practice made provision for people who could not speak English. This included employing multi-lingual staff and access to interpreting services. Information was available in a range of languages to ensure all patients had information in accessible formats. Both staff and patients were aware of the chaperone policy and there were signs in reception reminding patients of the policy.

Our findings

Respect, dignity, compassion and empathy

We spoke with 12 people and received 12 completed comment cards. All the people we spoke with commented that staff were friendly, courteous, polite and respectful. Patients said they were always treated with dignity. Patients gave us examples of how staff treated people this included providing emotional support and being compassionate when they had suffered a bereavement, responding with empathy when giving bad news and respecting their religious or cultural beliefs; adapting care or treatment to reflect this. People told us that they could speak with staff in private if they needed to and some of the people we spoke with were aware of the chaperone policy, if they needed someone else to be present during an intimate examination.

We observed positive interaction between staff and patients during our visit. Staff were polite, helpful and took time to explain things. This was particularly important because 55% of patients were from the Tamil community and English was not their first language. We saw that staff responded well to people and where possible staff who could speak the patient's language was asked to intervene. There was also an interpretation service available if patients preferred or needed it to cover languages staff did not speak.

Staff also explained how they were caring and responsive to the needs of patients with memory of mental health problems. They described how some patients with conditions such as Alzheimer's or other forms of dementia would call the practice six to seven times a day about the same issue. Staff explained that they responded to such patients with care and patience. Also patients with mental health conditions may call wanting to speak with a GP. Staff said they always tried to accommodate such requests if possible or they would ask the GP to return the call to alleviate the patient's anxiety. The practice also had a policy in place that if a person with a mental health or memory condition attended an appointment late, they were still seen.

Involvement in decisions and consent

Patients we spoke with told us they were involved in making decisions about their care and treatment. Staff told us that patients with long term conditions were involved in decisions about their care during reviews. For example one

Are services caring?

patient told us that the GP advised them of changes that may be required in their medication and discussed this over making lifestyle changes. The patient was encouraged to get involved and make decisions about the appropriate treatment.

In response to the needs of diabetic patients and ensure they understood treatment options the practice had developed literature to meet people's needs. They had produced a booklet in Tamil explaining what diabetes is, its treatment, lifestyle changes and management. The booklet was a comprehensive and accessible tool to ensure that patients were able to be involved in the planning of their care. The practice had also produced an easy read booklet for breast cancer screening.

Staff were aware of the Mental Capacity Act 2005 and one of the GP's we spoke with explained comprehensively when they would consider a best interest meeting and steps to take if a patient lacked capacity.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had a high number of people from the south Asian population and staff in the practice spoke 14 different languages to meet some of the language barriers for patients. Patients were signposted to counselling and other psychological services if required. There were a number of patients with long-term conditions such as diabetes and high blood pressure. The practice had links with external organisations to meet the needs of these patients, including other local health services. The practice had positive relationships with cultural organisations to further support patients. The practice was open during core times and offered appointments throughout the day, providing good access options for all groups. Emergency appointments were available. We reviewed the practice complaints log and saw that complaints were handled and processed in line with their policy.

Our findings

Responding to and meeting people's needs

The practice was able to demonstrate how it planned the services provided based on the varying needs of the population it served.

The staff workforce was multi-lingual with staff speaking 14 different languages to enable them to meet the needs of patients. Staff alerted people with visual impairments when it was their turn to see the GP. Approximately 9% of patients suffered from diabetes and the practice had information and advice for patients with this illness. The literature was readily available in English and Tamil and could be produced in other languages if required. Sexual health leaflets were also available in various languages.

Patients experiencing psychological or emotional difficulties could access counselling services and were signposted to these in a way that suited them. For example, a counsellor who worked for the mental health service visited the practice one day a week. GP's referred patients to this service and they could book one to one appointments with them. They provided a range of services including lifestyle advice for people with long-term conditions, stress or mental health management. The senior partner had also forged strong links with the local Hindu temple to share information about the practice and the counselling services on offer with those that did not always wish to engage with mainstream services. This was to ensure patients who did not always wish to access mainstream services had access to

Routine referrals were processed through the choose and book system. Urgent two week referrals were faxed to the referring agency and staff rang them after two days to ensure they had been received. This was to ensure there were no delays in processing them.

Access to the service

The practice was open Monday to Wednesday from 8am-8pm, Thursday and Friday from 8-6.30pm for appointments. People could book appointments with a doctor or nurse during these times. The practice also opened on Saturday mornings from 9.30am-12.30pm for pre booked appointments. This offered access options for the working population and parents who needed appointments outside of school times.

Are services responsive to people's needs?

(for example, to feedback?)

Patients could visit the practice or call to make an appointment. Patients we spoke with told us that sometimes it was difficult to get through via the telephone.

Prior to the inspection we reviewed data from the NHS Outcomes Framework relating to accessibility to services. The data showed that patients had worse than expected experiences of getting through to the practice and making appointments. Our finding from the inspection showed that the problems related to getting through on the phone were linked to language barriers of patients and people who booked appointments and did not turn up (DNA's). Staff told us that a high proportion of patients were from the Tamil community and English was not their first language. For this reason when patients called the surgery their calls took longer than average to deal with. This was because either staff had to spend longer on the phone or they had to put people on hold so that staff who could speak the patients language was free to deal with the call. To mitigate the waiting times the provider had implemented a new telephone system which appeared to be effective. The new system allowed the practice to put calls on hold and place patients in a queue so that other calls could still be answered while people are waiting on the phone. The practice was also implementing a text reminding service so patients were alerted prior to their appointment.

The practice made slots available for emergencies so that people could be seen by a GP on the same day if required.

Patients we spoke with were happy about the availability of emergency appointments and said they were always available if required. This was particularly relevant to children and if parents requested an appointment for their child on the same day they were usually given one.

Approximately 9% of patients in the practice had diabetes. Recommended guidelines suggest that where this is the case a practice should consider offering an insulin conversion service, usually provided by a practice nurse. Insulin conversion is when a diabetic patient needs to move from tablets to insulin and they are referred to the hospital for this conversion to happen. An insulin conversion service is where a practice provides the service to patients in the surgery without the need for referral to hospital.

Concerns and complaints

A log was kept of all complaints and any actions taken. Patients were made aware of how to make a complaint through information on the practice website and posters in the reception area. Patients we spoke with during our inspection told us they knew how to make a complaint and felt confident that if they needed to complain it would be handled appropriately. We reviewed the complaints log and found that complaints were handled in line with practice procedure, including responses within the stipulated timescales.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The practice had a written business development plan with a mission statement. It clearly identified the areas of the business that required development. We saw that they had involved the Patient Participation Group (PPG) and the staff when planning developments relating to the practice. There were joint working arrangements with other practices in the area and they worked well with each other to develop and improve services for patients. Staff told us they were well supported and the management lines of responsibility were clear. The practice carried out staff and patient satisfaction surveys to gain feedback and help them improve.

Our findings

Leadership and culture

We spoke with the two senior partners and the practice manager and they all articulated the values and vision of the practice. We read the practice business plan which had been developed by the partners and the practice manager in conjunction with stakeholders including the Patient Participation Group (PPG) and staff. The plan had a clear mission statement that outlined the current service profile. It included details of the practice development priorities, how they planned to achieve them and the barriers that could prevent them occurring. This included promoting patient's rights, achieving better outcomes for certain groups and achieving equality in the delivery of care. There was a clear sense of leadership from the senior partners and staff conveyed positive attitudes towards the management.

Governance arrangements

Roles and responsibilities were clearly defined in the practice. Some GP's had lead responsibility for certain areas such as safeguarding, over 75's and mental health. The nurse practitioner led on services for children including immunisations. Staff were aware of which GP had responsibility for each area.

Systems to monitor and improve quality and improvement

There were various regular meetings in place to ensure that quality was reviewed, risks were considered, understood and managed. For example, there were monthly practice clinical meetings, which were attended by the GPs and nurses. The practice also held risk stratification meetings every six weeks to identify the risks to patients in a specific population group and analyse their medical history. All clinicians in the practice attended as well as district nurses, palliative care team and social workers. This joint approach ensured treatment was planned to ensure risks were managed safely. Staff were able to describe how outcomes for patients had been improve as a result.

The provider was not a member of Urgent Health UK however they took part in external peer reviews and audits. Kings College Hospital audited the practice in 2013; looking at levels of obesity and working with patients on ways to reduce weight and increase physical activity. An overall aim was to reduce cardiovascular disease. This audit had a positive impact on the practice. One of the GP's told us that

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

the audit enabled them to identify all patients who were at high risk for cardiovascular disease. They invited all these patients to the practice for a check and were able to provide treatment (tablets and lifestyle advice). These patients were reviewed after three months

Other systems to improve the quality of the service included carrying out clinical audits and holding regular meetings between the partners in the practice as well as other clinical staff ,.and staff meetings every 2-3 months.

Patient experience and involvement

The practice regularly sought the views of patients. The most recent "Patient Voice Survey" carried out in 2013/14 showed that over 90% of patients were happy with the practice opening times and also felt they were treated with respect. Only 60% of patients were happy with the appointments system but we saw that the practice had made changes to the system since the survey was carried out, partly in response to the survey results.

Patients we spoke with were happy about the way the practice engaged with them and felt their views were listened to.

The practice had a Patient Participation Group (PPG) which met approximately every six weeks. We attempted to contact members after our inspection, but we were unsuccessful in doing so.

Staff engagement and involvement

Staff told us that they felt supported however the provider did not have arrangements in place to ensure staff were updated regularly and efficiently. Staff meetings were held on an ad-hoc basis; sometimes occurring every 2-3 months. We saw notes from the last meeting held on the 12 May 2014. The practice manager was responsible for co-ordinating team meetings and distributing minutes. Staff commented they did not always receive copies of the notes or action points from meetings and they did not know where they were kept.

Learning and improvement

There was a development plan which covered all key areas for the practice to review performance and make improvements. Staff were set individual and team objectives. The plan was managed by the practice manager and updated regularly by the senior partners in conjunction with the practice manger. Staff fed into the development through staff meetings.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Older People received a service which was caring, responsive and safe and responsive to their needs. There was a named GP for over 75's and annual health checks were available to them. All older people we spoke with were happy with

Our findings

The service responded to the needs of this population group. One of the GP's told us that the practice had an average to lower than average number of patients that were classed as older people. There was a named GP for the over 75's and they worked well with the group ensuring services met their needs. For example, GP's maintained a list for all housebound patients and ensured they received home visits if required. They also provided annual health checks for the over 75's. All people within this group were offered a free annual flu jab and bi-annual pneumonia jab.

Generally people in this group felt that staff were caring and responsive to their needs. We saw that staff interacted well with patients and treated them with courtesy and respect. All vulnerable adults aged over 65 were set up with alerts on the computer system so staff was aware of this and could offer relevant support.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Overall people with long term conditions received a service that was caring, responsive, effective and safe. The practice organised and arranged care in line with patients' needs including; ensuring reviews were completed.

Our findings

Overall the service responded well to the needs of this population group. We saw that reviews of long term conditions such as high blood pressure, atrial fibrillation (AF) and diabetes were prompt and people were contacted if they did not attend for their reviews. There was a system in place where non-attendance to reviews was recorded. If a patient did not attend then their repeat prescription would not be processed

All new patients with long-term conditions had to see a doctor before any repeat prescribing was authorised. This was to ensure patients medications and treatment had been monitored.

Data we reviewed prior to our inspection showed that the practice had a high level of diabetes. . Practice staff were aware of the data and were able to explain the reasons for it, including the demographics of the local population and how they helped patients to manage their condition. For example, the practice had close links with the community diabetic liaison team (people could be referred to the team for additional support) and regular reviews to monitor conditions. The practice demonstrated that they proactively encouraged patients through education and reminders to assist in controlling the condition as best as they could.

Annual health checks were available to all people with long term conditions, as were annual flu vaccinations and bi-annual pneumonia vaccinations

The practice had developed literature in a variety of languages for their diabetic and asthmatic patients. The booklets were comprehensive and they included information about the two conditions, safe management and control of the conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Overall mothers, babies, children and young people received a service that was caring, responsive and effective. The practice had processes in place to protect babies health needs and promote healthy development.

Our findings

The practice had a high number of children receiving their immunisations. Effective systems were in place to ensure babies and children received immunisations at the right times. This included contacting parents when they saw that an immunisation was overdue. There were a high number of patients who were from abroad. The practice was proactive in contacting the relevant Embassies of children who were from abroad to get details of immunisations traditionally administered by the country of origin. This was to enable them to have an idea of the immunisations the child may have received. If they were unable to establish then they would give the recommended immunisations in line with guidance.

Babies and young children were usually given same day appointments because staff explained they did not want to take risks if a parent presented with a sick child who could not explain their pain or illness.

The nurse practitioner ran ante-natal and post-natal appointments. Pregnant women and children under four were offered the annual flu vaccination and bi-annual pneumonia vaccination.

There were a range of services and literature available for young people in relation to sexual health. The practice used to run sexual health clinics however they reviewed the effectiveness of this and realised there was a higher up take for one-to-one sessions. Young people could therefore make an appointment at any time to see a GP or nurse for sexual health advice or contraception. Leaflets were available in multiple languages and there was information on the practices website promoting the service.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The working age population and those recently retired received a service that was safe, caring and responsive to their needs.

Our findings

The service responded well to the needs of this population group. Health checks were available for the over 50's, the practice opening hours was reflective of the needs of working people in that they operated evening and Saturday appointments to make it easier for people to book appointments outside of work time.

Health promotion services were available including one to one sessions with a "living well" counsellor who could advise on healthy eating, exercise and weight problems.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Overall people in this population group received a service that was safe, effective and caring. Access to care appropriate and responsive.

Our findings

There were a small proportion of patients who were refugees. The practice had appropriate support and counselling services in place should they require them. They had access to on-site counselling sessions every week and care and treatment was planned taking account of their experiences.

The practice maintained a list of all patients with a learning disability. Annual health checks were carried out and the practice had completed 100% for all patients with a learning disability for the previous year. One of the GP's in the practice met with a learning disabilities specialist nurse every three months. During these meetings they discussed all patients on the learning disabilities register and explored how they could improve their lifestyle and improve health.

Literature was available in easy read different formats and various languages. They had designed a breast screening leaflet in easy read format for people with learning disabilities and older people.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Overall people with mental health problems received a safe, responsive, caring and effective service. Appropriate support was in place to encourage patients to stay well.

Our findings

Systems were in place to ensure people in this group had access to the service. If people with mental health problems arrived late for appointments they were always seen because the practice was considerate to their conditions and took this into account.

One of the GPs had lead responsibility for mental health. They had good links and met regularly with the community mental health services. The practice maintained a register of all patients experiencing severe mental health illnesses. We were told that 88% of current patients with a learning disability had a care plan in place which was updated regularly (generally annually but shorter intervals if required). We saw template care plans for people in this group and they incorporated all the relevant areas that should be included. Patients on lithium had regular blood testing at the practice and checks were carried out before any new medication was prescribed to ensure it was safe.

Annual health checks had been completed for 91per cent of all mental health patients which included blood testing. The practice manager told us that this group was traditionally hard to engage.