Clover Health Centre

Quality Report

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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 safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Clover Health Centre on 10 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for the population groups: Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); People whose circumstances may make them vulnerable; and People experiencing poor mental health (including people with dementia)

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and were being met.
- Patients said staff were caring, they were treated dignity and respect, and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice was making it easier for patients to make an appointment with a named GP and patients said the regular doctors and nurses provided continuity of care. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice acted on feedback from patients and staff.

We saw one area of outstanding practice:

Summary of findings

- The practice worked with Public Health to put in place a Somali health advocate to support women whose circumstances made them vulnerable to access services. It had improved its cervical screening rate notwithstanding the challenges of serving a highly mobile population.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider must

- Assure itself that the building's landlord is taking the necessary steps to reduce the risk of Legionella infection to staff and patients.

Put in place a schedule of routine maintenance, testing and recalibration for all the practice equipment to mitigate the risk of this activity not being picked up once warranties expired.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed many patient outcomes were at or above average for the locality, and the practice was improving outcomes where performance was less than average. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was making it easier for patients to make an appointment with a named GP and patients said the regular doctors and nurses provided continuity of care. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to

Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints as shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and there were regular board meetings to oversee the running of the practice. There were systems in place to monitor and improve quality and identify risk, and regular performance and contract review meetings with the commissioner. The practice acted on feedback from staff and patients. The patient participation group (PPG) was in an early stage of development and active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. People aged 65 and over made up less than two per cent of the practice' list of registered patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 people who had a high number of A&E attendances. The practice was improving immunisation rates for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice took the initiative in improving joint working with other health professionals, for example midwives.

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. The practice was proactive in a full range of health promotion and screening that reflects the needs for this age group, and was improving the uptake of these services.

Summary of findings

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. It had carried out annual health checks for people with a learning disability on its list, and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It also referred patients to a range of psychological therapies and self-help groups in the community. However the practice needed to improve the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record.

Summary of findings

What people who use the service say

We spoke with ten patients during our visit and reviewed the 18 comment cards that patients had left for us during the two weeks prior to our visit.

The patients we spoke with said they received good quality care in a safe environment. Six of these 10 patients were registered with other local practices but could not be seen there quickly enough. The walk-in centre was especially popular with mothers with small children and with younger adults. Two of the four registered patients had left other local practices to join Clover Health Centre. Patients commented favourably on the extended opening hours and same day appointments, even if this meant waiting up to three hours as a walk-in patient. Registered patients commended the care they received from named GPs and nursing staff. A few told us that the care they received from locum doctors was less good.

Sixteen of the 18 comment cards gave positive feedback about the practice. Again, named GPs and nursing staff were commended for the care they provided. Staff in general were described as polite, helpful and caring. One of the 18 comment cards described the service as very poor, however. And another asked that information about waiting times for the doctors and nurses be displayed in the waiting area.

The results of the national GP patient survey published in July 2014 showed Clover Health Centre compared well with other practices in Greenwich in the following areas:

- Respondents are satisfied with the surgery's opening hours (88% compared with the Greenwich average of 75%).
- Respondents saying the last GP they saw or spoke to was good at involving them in decisions about their care (73% compared with the Greenwich average of 75%).
- Respondents having confidence and trust in the last GP they saw or spoke to (90% compared with the Greenwich average of 93%).

Clover Health Centre compared less well in the following areas:

- Respondents usually waiting 15 minutes or less after their appointment to be seen (43% compared with the Greenwich average of 62%).
- Respondents with a preferred GP usually gettting to see or speak to that GP (39% compared with the Greenwich average of 57%).
- Respondents describing their overall experience of this surgery as good (67% compared with the Greenwich average of 83%).

This was based on a 23% survey completion rate (234 surveys sent out and 99 surveys sent back).

Areas for improvement

Action the service MUST take to improve

- Assure itself that the building's landlord is taking the necessary steps to reduce the risk of Legionella infection to staff and patients.
- Put in place a schedule of routine maintenance, testing and recalibration for all the practice equipment to mitigate the risk of this activity not being picked up once warranties expired.

Outstanding practice

The practice worked with Public Health to put in place a Somali health advocate to support women whose circumstances made them vulnerable to access services. It had improved its cervical screening rate notwithstanding the challenges serving a highly mobile population.

Clover Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team also included a GP Specialist Advisor and an Expert by Experience. Specialist Advisors and Experts by Experience are granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Clover Health Centre

Clover Health Centre is located in Woolwich, Greenwich in South East London. It is open from 8am to 8pm, seven days a week, and 365 days a year. It has approximately 5,000 registered patients and sees on average 1,200 walk-in patients a month.

These services are provided by Greenwich Primary Care Collaborative (GPCC) which is a Community Interest Company (CIC) set up and owned by about 80 local health professionals. In May 2011 GPCC was awarded a five year Alternative Provider Medical Services (APMS) contract to provide a GP service and a GP-led Walk-in Centre from a newly refitted primary care facility. It shares these premises with some community health services provided by a local NHS Trust, including the Contraception and Sexual Health (CASH) clinic, Musculoskeletal (MSK) Integrated Clinical Assessment and Treatment Service (ICATS), and blood services.

Clover Health Centre (CHC) employs two GPs, one male and one female; a female nurse practitioner and a male practice nurse; a practice manager; and administrative and reception staff. It also uses locum doctor and nursing staff to bring the total clinical staff complement to 4.85 full-time equivalent staff. CHC endeavours to limit the pool of locum staff it uses to maintain continuity of patient care.

One of the GPs is the Local Medical Director of CHC. They and the Practice Manager are members of the Greenwich Primary Care Collaborative and take part in its monthly board meetings.

Clover Health Centre serves a highly mobile and deprived population. It is located in an area that is in the second most deprived ten per cent of all areas in England, and it experiences a 10% turnover in its practice list every quarter. This makes meeting screening and immunisation targets challenging.

CHC's list of registered patients is made up of a greater proportion than the England average of people aged 24 to 39 years and babies and children aged nought to four years. There are comparatively very people aged over 65 years. One third of the practice's registered patients had never had a GP before.

The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place. There is insufficient data to place Clover Health Centre in a band; however a few areas of risk or elevated risk are identified:

- Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2013 to 31/03/2014)

Detailed findings

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2013 to 31/03/2014)
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 9 months is 150/90mmHg or less (01/04/2013 to 31/03/2014)
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months (01/04/2013 to 31/03/2014)
- The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years (01/04/2013 to 31/03/2014)

Greenwich Primary Care Collaborative CIC is registered with the Care Quality Commission to carry on the following regulated activities at Clover Health Centre: Treatment of disease, disorder or injury; Diagnostic and screening procedures; and Maternity and midwifery services.

Clover Health Centre has opted out of providing out-of-hours services to its own patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service 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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, including Healthwatch Greenwich, Greenwich Clinical Commissioning Group and NHS England. We carried out an announced visit on 10 December 2014. During our visit we spoke with a range of staff, including GPs, the practice nurse and nurse practitioner, the Practice Manager, and administrative and reception staff. We spoke with patients who used the service and members of the Patient Participation Group. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed documentation the provider gave us about the operation, management and leadership of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. One example of a recently reported incident was the delayed diagnosis of cancer in one patient. The significant event record showed that all relevant personnel had been involved in reviewing the incident and identifying the key risk issues for the practice. There was an action plan in place to prevent the reoccurrence of a similar incident, with named individuals and deadlines set to ensure each action point was completed. Minutes of Greenwich Primary Care Collaborative (GPCC) Board meetings showed that significant events were discussed at these meetings to ensure the leadership of the organisation maintained an overview of the safety of the service. Adverse incidents were also reported o NHS England who commissioned the service from GPCC.

We reviewed safety records, incident reports and minutes of board meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events and we reviewed the records for the last 12 months. Significant events was a standing item on the monthly board meeting agenda. Significant event records showed relevant staff were involved in reviewing and disseminating learning from events. Records did not show that actions plans had been formally reviewed and signed-off when completed. Interviews with staff and correspondence showed the practice had taken action to remedy matters and prevent incidents from reoccurring. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the Practice Manager. He showed us the system used to manage and monitor incidents. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example to remedy repeat prescription errors. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated to staff using the practice's messaging system. The Practice Manager ensured clinical and non-clinical staff received the appropriate alerts. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts could be discussed with colleagues when necessary. There were no regular formal practice meetings, however all staff told has that they had good access to their peers, line managers, clinical supervisors and the Practice Manager. Staff commented that there was very little time in which to have regular, formalised meetings. Documents showed meetings were held when necessary, for example to discuss the results of the national GP patients survey areas for improvement.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, the nurse practitioner was the lead for safeguarding children and had received level 3 child protection training All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans, housebound patients, and patients requiring same day appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us they were comfortable acting as chaperone when called on to do so and demonstrated understanding of what the role required. Criminal records checks through the Disclosure and Barring Service (DBS) had been completed for staff acting as chaperones. The practice provided culturally sensitive chaperone arrangements for some women having cervical smears whose circumstances made them vulnerable and had enlisted the support of a female Somali health advocate.

Other provisions the practice made for the population groups it served included monitoring A&E attendances for children and young people and people with long term conditions, including chronic pulmonary obstructive disease (COPD) and diabetes. There were protocols in place for walk-in patients, for example around the management of long term conditions, tests, and prescribing, to ensure they received appropriate and safe care coordinated with the care they received from their own GP.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. There was a system in place for routinely checking and recording the temperature of the medicines refrigerator.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice followed the local Clinical Commissioning Group's (CCG) guidelines for antibiotic prescribing; however its level of antibiotic prescribing was high compared with other practices in the CCG area. The practice attributed this to being a walk-in centre. A work plan was in place, agreed with the CCG's prescribing advisor, to bring about improvements in Clover Health Centre's prescribing practice, and it had completed the medicines management audits required by the CCG. There were areas in which Clover Health Centre compared favourably with other practices in the CCG, and in the 12 months to June 2014 it had improved in most of the areas where it had compared less well with other practices, including antibiotic prescribing.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. The nurse practitioner was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Flags on patients' electronic notes alerted staff when a blood test was required before further medication could be prescribed. We checked 10 patient records which confirmed that the procedure was being followed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely at all times.

The practice did not hold stocks of controlled drugs.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We observed good infection control practice, for example optimum hand hygiene and the safe handling and disposal of sharps and clinical waste. The practice had a dirty utility room and procedures were in place for

managing blood and bodily fluids safely. We did not see evidence that the lead had carried out a formal audit; however we were told that one was planned for 16 December 2015.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a Legionella management policy (a bacterium that can grow in contaminated water and can be potentially fatal). However it was unable to provide us with records to confirm the landlord was taking the necessary steps to reduce the risk of infection to staff and patients.

The practice had an Ebola action plan in place.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We observed equipment was in good working order and staff told us all equipment was well maintained. Much of the equipment in the practice was still within the manufacturer's warranty period, and a schedule for the routine maintenance, testing and recalibration where necessary of the practice's equipment was still to be put in place, including portable electrical equipment testing. Some of the equipment was rented and the maintenance and repair of this equipment was covered by the rental agreement.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave, and overtime and enhanced payments were available. Staff turnover was low.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The Practice Manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The practice was very pleased that it had been successful in recruiting an additional GP to cover for maternity leave in the first instance, and to support the provider's plans for continued growth thereafter.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Minutes of the monthly board meetings demonstrated the provider was alive to, and took action to mitigate the risks to the operation and performance of the service. The organisation did not maintain a risk log, however.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, same day appointments were made available for patients with acute needs and unwell children. Protocols were in place to ensure patients contacting the practice were met with the right level of response, for example a call back from the

Good

Are services safe?

GP within 20 minutes or within 60 minutes. The protocol also set out when 999 should called, for a patient who is breathless or unconscious, threatening suicide, or having a seizure.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Actions were set out to reduce and manage the risk and the document also contained relevant contact details for staff to refer to. Risks identified included power failure, unplanned absence and access to the building, for example. The practice's computer records could be accessed from outside the Clover Health Centre if the service had to be temporarily relocated.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. The alarm system and extinguishers had been serviced within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses and review of patient records that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We reviewed the notes of 24 patients, including patients with a learning disability, cancer, dementia, depression, rheumatoid arthritis, diabetes or chronic obstructive pulmonary disease (COPD). The notes showed patients' needs were being assessed and met.

The practice had been commissioned to provide an enhanced service to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who were at high risk of hospital admission or readmission. In line with the enhanced service requirements, the practice had used computerised tools to identify the two per cent of its registered patients most at risk and care plans had been put in place to prevent unplanned admission.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards, for example for the referral of patients with suspected cancers to be seen within two weeks. We saw that elective and urgent referrals were reviewed and individual GPs, including locums, received feedback from the Local Medical Director.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of a patient's age, gender, race and culture as appropriate. The practice had an open registration policy and took pride in registering patients who had been turned away from other local practices. Staff viewed this as part of their core purpose.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included for example data input, and managing child protection alerts and medicines management. The information staff collected was then collated by the Practice Manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been undertaken in recent years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The changes had brought about significant improvement in vitamin D prescribing practice and a lower rate of inadequate smears.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice was improving in those areas where its performance was below target, including cervical screening, childhood immunisations and preschool boosters, and influenza immunisations for patients aged over six months to under 65 years in clinical risk groups. It was achieving this despite the demographic challenges presented by its practice population, by offering dedicated weekend immunisation clinics and working with a Somali health advocate to support women having a cervical smear

Good

Are services effective?

(for example, treatment is effective)

for example. We also saw examples of staff taking time to explain the benefits of health screening and promotion, sourcing information in community languages, and providing opportunistic screening and immunisation.

In addition to the national measures of performance the practice had a set of local key performance indicators set by NHS England as part of the Alternative Provider Medical Services contract. Many of these related to access, and the practice was meeting its targets, for example for the amount of time a patient might have to wait to see a GP or other primary care professional and access to the GP of choice. Some performance indicators were specific to the needs of the practice catchment area and related for example to recording patients' ethnic origin and first language.

The team was making use of clinical audit tools and clinical supervision. The staff we spoke with discussed how, as peers and colleagues, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement and their mission to provide the very best possible care for every patient.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and nursing staff. The Local Medical Director had an interest in teaching and was developing this. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example we saw that the practice nurse had been supported to complete training on COPD and Paediatric Asthma, Nursing in Practice, and Assessment of minor illness and injuries in 2014, as well updates on immunisation and COPD.

The nurse practitioner and practice nurse were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles, including seeing patients with long-term conditions or tissue viability needs were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. A protocol was in place for referring patients to the mental health team in and out of hours and we also saw patients being referred to homeless substance misuse services. Patients were also signposted to relevant support groups including for example CRI Greenwich Aspire, a charity providing free treatment and support to vulnerable people facing addiction, homelessness and domestic abuse; and Solace Women's Aid which is charity providing practical and emotional support to survivors of violence.

A few significant events had been raised about patients having poor access to other services. As well as taking action to improve access, for example by producing patient information in community languages about self-referral to the community midwifery team, the practice also raised the issues with services and with commissioners.

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service. Procedures were in place for dealing with this correspondence effectively, ensuring it was passed on to the relevant staff and acted on in a timely way.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and

Good

Are services effective?

(for example, treatment is effective)

commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, patients with a learning disability were given longer appointments so that there was more time for the health professional to explain the treatment and care being offered and gain the patient's informed consent.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering information and advice about screening and childhood immunisations.

The practice identified patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and practice records showed they had all received a check up in the last 12 months. Also, the practice was setting up a weight management clinic for patients who were obese.

The practice's performance for cervical smear uptake had improved to 69%, as reported to the board in December 2014. This was attributed to work undertaken by the practice to raise awareness, support women in vulnerable circumstances, and provide opportunistic screening. Local performance indicators were in place to identify and encourage patients to attend breast screening and bowel screening when appropriate, and the practice was performing well against these targets.

The practice's performance for childhood immunisations and preschool boosters was also improving. Non-attenders were identified and nursing staff followed these up.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published July 2014 and patient satisfaction questionnaires sent out to patients by the Local Medical Director. The evidence from these sources showed patients were involved in decisions about their care and had confidence and trust in their GP.

The national patient survey also identified areas for improvement. The practice had developed action plans to:

- Increase the proportion of patients able to see their preferred GP.
- Increase the proportion of patients waiting 15 minutes or less after their appointment time to be seen.
- Increase the proportion of patients who found it easy to get through on the phone.
- Reduce the proportion of respondents who express concern about privacy in the reception area.

The practice was developing its own survey in collaboration with its Practice Participation Group, and it had implemented the NHS Friends and Family Test (FFT). FFT is a feedback tool that supports people who use NHS services to provide feedback on their experience that can be used to improve services. It is a continuous feedback loop between patients and practices.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered good quality care and staff were helpful, polite and caring. Two comment cards were less positive but there were no common themes to the issues raised in these. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by their regular doctors and nurses.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice had a named Caldicott Guardian, who was responsible for ensuring the safe keeping and appropriate use of information. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

In response to concerns about privacy in the reception area, the practice had trialled using airport style barriers to keep people from crowding the reception desk. However these proved unpopular with many patients and were removed. Staff were continuing to look for ways to channel one patient at a time to the reception desk to prevent patients overhearing potentially private conversations between other patients and reception staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 73% of respondents said the GP involved them in care decisions. This compared well with the Greenwich average of 75%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them in detail and they felt listened to and supported by staff.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

A few patients we spoke with and patient comment cards detailed how the whole practice helped them overcome problems that extended beyond their medical ones.

Good

Are services caring?

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. We saw examples of the practice providing support to carers, for example offering them the influenza vaccination.

Staff told us the practice supported families that had suffered bereavement, referring them to Greenwich Cruse Bereavement Care where appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice engaged regularly with NHS England as part of the Alternative Provider Medical Services (APMS) contract monitoring arrangements. Key performance indicators had been identified and built in to the contract to address local needs and bring about local service improvements and we saw minutes of quarterly joint service reviews meetings where they were discussed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, in response to concerns about privacy in the reception area, the PPG had suggested using airport style barriers to keep people from crowding the reception desk, and the practice had trialled this. However the barriers proved unpopular with many patients and were removed. The PPG was working with staff to find other ways of preventing patients overhearing potentially private conversations between other patients and reception staff.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service, for example Muslim women of African or Asian origin, people with a learning disability, and homeless people and people of no fixed abode.

Languages spoken at the practice in addition to English included Malay, Punjabi and Turkish. The practice had access to online and telephone translation services and interpreter services. We observed receptionists handling calls and talking to patients. They were polite, smiling and helpful. They were confident, comfortable and respectful in their dealings with the wide diversity of patients coming to the practice. They told us they would have no hesitation in reporting to the Practice Manager any discriminatory or abusive behaviour that they observed, although they could not imagine the situation arising.

The premises and services had been adapted to meet the needs of patient with disabilities. All the consulting and treatment rooms were accessible to wheelchair users and there was a hearing loop in place. The practice was on the first floor and there was a lift up to the first floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 08.00 am to 08.00 pm seven days a week, 365 days a year.

Comprehensive information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange same day appointments, urgent appointments, longer appointments, telephone consultations and home visits. Routine appointments with any available GP were available within 48 hours, and appointments could be booked up to four weeks in advance. A routine appointment to see a preferred GP may take up to three to four weeks, but the practice was working to improve this.

We saw examples of patients' notes flagging up to staff when the patient was always to be offered a same day appointment (the patient had cancer), or that a patient was housebound and would require a home visit. We saw that the GP had visited the housebound patient in their home after a telephone consultation, and taken a chaperone with them because an intimate examination was going to be necessary.

Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them, and could also be booked for cervical smears, discussing multiple problems, medicals, postnatal checks, psychological issues, well-baby health checks and immunisations. This included appointments with a named GP or nurse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. For example, one person had phoned for an appointment at 10.30 am and was told to come in at 11.15 am.

The practice's extended opening hours every day of the year were particularly useful to patients with work commitments and students, and a few patients we spoke with highlighted the opening hours is as something they really liked about the practice. The opening hours also meant that appointments were available outside of school hours for children and young people. The premises were suitable for children and young people.

Sharing the premises with the contraception and sexual health (CASH) clinic improved access for the practices' patients to these services.

The practice had a comparatively high student population as it was located close to a further education college. The practice used text appointment reminders which were particularly effective with these younger adults. The practice did not have online appointment booking and repeat prescription services.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information was available on the practice website and there were complaints leaflets in the waiting area.

We looked at seven complaints received in the last 12 months and found they had been investigated thoroughly and responses had been sent to the complainants in a timely way. The practice maintained a complaints log to make it easier to detect themes or trends. No themes or trends were identifiable from the complaints received in the last 12 months.

Are services well-led?

Good

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

Our findings

Vision and strategy

Greenwich Primary Care Collaborative (GPCC) had a clear vision, A New Vision for Health, to deliver high quality services and to meet unmet need. It sought to enable all local practices to benefit through collaboration, sharing resources and applying best practice. Training was at the heart of its offer and there had been 15 educational events since September 2013. GPCC had been asked to be part of a community education provider network that was being set up by NHS Health Education South London.

Staff we asked about the aims and the purpose of the service were aware of A New Vision for Health and demonstrated commitment to providing the very best possible care for any patient coming to Clover Health Centre for treatment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. They were available electronically and in hard copy within the practice, and each member of staff had been given a CD with all the policies and procedures on. We looked at 12 key policies, for example around safeguarding, health and safety, and confidentiality and staff we spoke with demonstrated knowledge and understanding of these polices. All 12 policies and procedures we looked at had been reviewed within the last 12 months and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GPs was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) and locally determined indicators to measure its performance. Action plans were in place to improve performance in those comparatively few areas where performance was not meeting targets, and improvements were being made.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Most recently, it had completed the first cycle of an audit of prescribing paracetamol for children.

We saw that the practice and the provider were alive to the challenges facing the organisation and planned action to mitigate these risks; however there was no formalised risk log.

Staff regularly had informal and impromptu discussions with colleagues and peers and practice meetings were convened when required. However, staff told us that the practice had fallen out of the discipline of having formalised regular clinical, team and practice meetings. The Local Medical Director and Practice Manager were members of GPCC and took part in the monthly board meetings.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with their peers, line managers and clinical supervisors.

The Practice Manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy, induction programme and whistleblowing policy which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the national GP patient survey and was taking effective action to improve patients' experience of the service in the three areas where improvement was most needed:

- The practice had worked in greater flexibility in its appointment system and introduced telephone encounter slots to enable more patients to see or speak to the GP of their choice on the same day or by booked appointment within 48 hours. A designated administrator had real time access to the appointment

Are services well-led?

Good

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

system to monitor demand of the various users of the service and adapt appointment slots accordingly, for example switching appointment slots for walk-in patients to registered patients.

- The designated administrator was tasked with informing the Practice Manager or Local Medical Director of any patient waiting more than 15 minutes. With the patient's consent they could then be transferred to another clinician's list.
- The practice had invested in and installed a new telephone system to make it easier to get through to the practice by phone. The number of lines has been increased from four to 20, and outgoing calls no longer prevent incoming calls from being answered

The practice had a patient participation group (PPG) which was in the early stage of development. Its few members were keen to get involved in helping the practice to improve and were working with the Practice Manager to increase the size of the PPG.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared the outcomes with relevant staff to ensure the practice improved outcomes for patients. For example repeating prescribing systems and procedures were modified and improved to meet patients' needs better and more safely.