Crest Medical Centre

Quality Report

Crest Medical Centre
157 Crest Road
Neasden
NW2 7NA
Tel: 020 8452 5155
Website: www.nhs.uk

Date of inspection visit: 25 March 2015
Date of publication: 10/09/2015

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Crest Medical Centre on 25 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe services. It was also good for providing services for older people, people with long term conditions, families children and young people, working age people including those recently retired, people whose circumstances make them vulnerable, and people experiencing poor mental health (including those 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, with the exception of those relating to recruitment checks.
- 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 planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider must:

- Ensure all staff have undertaken training in child protection and safeguarding adults.
- Ensure all staff have the required recruitment checks carried out and recorded prior to starting their employment.

In addition the provider should:

- Ensure that all actions to improve fire safety which were identified in the fire safety audit are completed.
- Ensure audit cycles are completed to drive continual improvement.

Update the practice website to reflect the results of the most recent patient survey.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, training records indicated that not all clinical staff had received mandatory training in child protection and safeguarding adults. Although risks to patients who used services were assessed, improvements to processes were required with regard to the recruitment process, as not all staff members had a written reference on their recruitment file. Risks to patients and staff had been assessed, however improvement action from the fire safety audit was still to be completed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Generally staff had received the training appropriate to their roles. The practice had identified not all staff had received safeguarding training and this was being planned. 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 for patients about the services available was easy to understand and accessible. 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. 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 held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had attended 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 offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

All patients over the age of seventy five had a named GP. A privately hired physiotherapist worked at the practice three times a month and offered a service to older patients with mobility problems. Sixty-seven per cent of older patients had received the seasonal flu vaccination, this compared to the national average of 73%.

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. The practice nurse specialised in diabetes and had undertaken training for this role. The practice was able to refer patients with diabetes to a local 'one stop shop' diabetic clinic. The specialist diabetic nurse had attended meetings with clinical staff to review patient care and offer advice on good practice. Eighty-four per cent of patients on the diabetic register had received their annual influenza vaccination in comparison to 93% which was the national average.

Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP 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 on the child protection register.

The practice offered antenatal care, six week mother and baby checks and childhood immunisations. Patients could book an

appointment with the practice nurse for these services. Ninety four per cent of children under two had received their childhood immunisations, with 100% of children under five receiving the full range of immunisations. One hundred per cent of children who had moved to the United Kingdom from abroad had received their hepatitis B vaccination. Staff informed us that in the case of a child from abroad not having an immunisation record they were offered the full range of childhood immunisations.

We saw good examples of referrals to specialist services for children. For example to CAMHS (children and families mental health services) as a result of assessment and consultation with the family.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Extended hours were available on Monday, Tuesday and Wednesday until 7:15pm for patients who were not able to see their GP during normal working hours or school hours. Extended appointments were available with the practice nurse on Monday until 7:15pm. Nine GP telephone consultations were available daily.

NHS Health Checks were offered to patients aged 40-74 years of age who were not already known to have any long-term conditions. The surgery achieved above their practice target last year on delivering NHS Health Checks.

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 with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up review.

Summary of findings

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. However, the practice training record did not indicate that all staff had received formal safeguarding training.

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). Ninety seven per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. GPs supported patients to access the mental health services they required within an NHS setting. One of the GPs at the practice had a special interest in mental health and had also worked within a mental health setting. As a result of this patients at the practice were referred to this GP by other GPs in the practice.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of patients undertaken by the practice's patient participation group (PPG) which had approximately 20 respondents. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated their experience of making an appointment as good. The practice was also rated above average for finding receptionists at the practice helpful; 90% of respondents said they found reception staff helpful in comparison to the CCG average of 84% and the national average of 87%. Information from the national patient survey also told us that 83% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%. Ninety five per cent said the GP gave them enough time compared to the CCG average of 93% and the national average of 95 %.

We received 20 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff were supportive and treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83%. Eighty two per cent said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 82%.

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients commented that staff explained their treatment options and involved them in decisions and they felt they received the appropriate treatment.

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and national average of 82%. Seventy nine per cent said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 98%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff have undertaken training in child protection and safeguarding adults.
- Ensure all staff have the required recruitment checks carried out and recorded prior to starting their employment.

Summary of findings

Action the service SHOULD take to improve

- Ensure that all actions to improve fire safety which were identified in the fire safety audit are completed.
- Ensure audit cycles are completed to drive continual improvement.
- Update the practice website to reflect the results of the most recent patient survey.

Crest Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and included a GP specialist advisor. The GP specialist advisor was granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Crest Medical Centre

Crest Medical Centre is located in a residential area of Brent and provides a general practice service to around 4,239 patients. The practice has a young population with a higher than average number of patients up to the age of 54. The practice has a lower than average number of patients over the age of 55. The practice has a multicultural population including English, Irish, Indian, Tamil, Sinhalese, Arabic, Somalian and Eastern European patients.

The practice was registered to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

The practice team comprises of one female and three male GPs, two practice nurses, two health care assistants, two phlebotomists, a practice manager and four receptionists and a private physiotherapist.

The practice operates a walk in system every weekday morning whereby patients can walk in between 8:45am to 10:15am and will be seen on a "first come first served basis." The practice closes at approximately 12:45pm and opens at 4:45pm for evening surgery. From Monday to Wednesdays, evening appointments are pre-booked from 5pm to 7pm. On Thursdays the practice operates the same morning walk in, but remains closed after 12:45pm. On Fridays, the surgery closes at 12:45pm and reopens again for pre-booked appointments from 4:30-6:30pm.

The practice has opted out of providing out-of-hours services to their own patients. The practice has an out-of-hours provider the details of which are on the practice leaflet. When the practice is closed, patients are advised to phone the out-of- hours provider or attend a local GP led walk-in centre which is open seven days a week until 8:00pm.

There were no previous performance issues or concerns about this practice.

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.

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:

Detailed findings

- 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)

For example:

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 March 2015. During our visit we spoke with a range of staff including GPs, the practice nurse and receptionist, and spoke with patients who used the service. We observed how people were being cared for and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice was monitoring safety and had 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. For example, as a result of a complaint by a patient about not receiving their test result, changes were made to the wording on pathology forms. The wording was reviewed and then revised to ensure patients understood the process for receiving their test results.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The system included reporting and recording significant events and complaints and reviewing these at staff meetings. We reviewed records of two significant events that had occurred during the last year and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. However, we looked at training records which showed that not all staff had received relevant role specific training on safeguarding. Training records indicated that two GPs had not received training in child protection in the last two years and one in safeguarding adults. In discussion with staff we were informed that the practice recognised that this training was mandatory and had applied for training with the local CCG which had been fully booked. All of the reception and administrative staff had received training in child protection and safeguarding adults.

The staff we spoke with 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 for local child protection and safeguarding teams were accessible and staff were aware of these.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. There was a standing agenda item of child protection and safeguarding adults at staff meetings which took place every two months. We saw minutes of meetings for November 2014, January 2015 and March 2015 where vulnerable patients were discussed.

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.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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). All nursing staff, including health care assistants, and reception/administrative staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring

Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw that a staff protocol for repeat prescribing was in place and this had last been updated in June 2014.

We saw records of prescribing audits which had been carried out in the previous twelve months. Data from audit informed us that the practice was prescribing against current guidelines. Eighty-seven percent of patients had received a medication review and 90% of prescriptions had been issued against current and up to date prescribing guidance.

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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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.

The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The majority of staff had received training about infection control specific to their role and received annual updates. Two staff had been booked onto infection control training.

We saw evidence of an infection control audit which had been carried out in April 2014 by the Infection Control Nurse for Brent and Harrow. We viewed the infection control audit and discussed the findings with the infection control lead at the practice. There were a number of areas where the practice was required to make improvements some of which were rated as high risk. Infection control risks had been identified in the areas of staff immunisations and occupation health awareness, cleaning policies, schedules and equipment, the sink area in consulting rooms and waste removal. The practice was able to demonstrate they had largely acted on the recommendations of the infection control audit, particularly where high risk areas had been identified for improvement. Where they had not, for example in the fitting of new hand wash basins they had modified this area to reduce risk.

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 policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).The practice had undertaken a risk assessment for legionella on 24 March 2015.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed

this. The portable electrical appliances had been tested (PAT) and relevant equipment (including blood pressure monitors, weighing scales and spirometers) calibrated on 13 March 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the recruitment records of four clinical members of staff, the majority of which had complete documentation. Staff recruitment files we viewed 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 the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). One of the recruitment files we viewed did not contain any references.

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.

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 met planned staffing requirements.

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 regular 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.

A fire safety audit had taken place in October 2014. Fire extinguishers had been serviced in March 2015 and we saw evidence of regular fire drills the last two being held in November 2014 and March 2015. We reviewed the fire safety audit and saw that a number of identified risks required immediate action. These were fire safety notices for staff and patients, fire signs, a review of emergency lighting and alterations to one fire exit door. We found that the alteration to the fire door was still pending. A fire door with a 'push bar' exit needed to be fitted. We discussed this with staff who said although this had been reviewed with a contractor a suitable mechanism was yet to be fitted.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw an example of this; we looked at the infection control audit and the fire safety audit and saw the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

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 in cardiac emergencies). 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 easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in February 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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. They told us this was downloaded from the website and disseminated to staff. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

A review of patient records and discussion with staff identified that patients had their health care needs assessed and were promptly referred to secondary healthcare services. For example, children on the chronic disease register were regularly reviewed and referrals made to the appropriate service. Patients who were newly diagnosed as diabetic were referred for diabetic eye screening and to the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme. Patients with a mental health condition had good access to the practice and were referred as required to psychiatric services. Feedback from patients confirmed they were referred to other services or hospital when required. We were given an example from a patient with their GP acting as advocate to ensure the most suitable service was accessed to meet their needs.

The GPs told us they lead in specialist clinical areas such as cardiology, dermatology and mental health and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, 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 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).

The practice showed us three prescribing clinical audits which had been undertaken in the last year and had been conducted for the CCG. They were all first cycle audits which meant the practice had not re-audited this information to measure their effectiveness for patients. An audit on the use of inhaled corticosteroids had been undertaken (corticosteroids are an anti-inflammatory medicine prescribed for a wide range of conditions including asthma). As a result of the audit it was ascertained that not all children with asthma were being

promptly referred to a paediatrician where necessary. The outcome of the audit was that all children were referred to the community paediatrician and are receiving growth monitoring.

An audit had taken place on the use of emollients for patients with skin conditions. There was no change as a result of this audit as patients were receiving the correct prescription and the GP had reviewed their condition and prescription. A re- audit of emollients had been set for 5 November 2015. The third audit looked at the prescribing of medicines for diabetes and if the practice was prescribing in line with NICE guidance. The practice had achieved 100% for appropriate prescribing. The date of re-audit had been set for 31 December 2015.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 90.9% of the total QOF target in 2014, which was below the national average of 94.2%. QOF indicators informed us that the dementia diagnosis rate for the practice stood at 46% which was below the national average of 54%. Seventy three per cent of patients with hypertension had received a blood pressure test in the last year compared to the national average of 54%.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. We looked at the minutes of the last thee staff meetings which had taken place in November 2014 and January, March 2015. Set agenda items were in place such as a review of significant events, complaints and appointments. The care of vulnerable adults was reviewed for example patients with mental ill health and housebound patients. The care of children at risk was also reviewed at staff meetings.

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 and infection control. Not all of the GPs were up to date with safeguarding and child protection training. We saw from staff meeting minutes that the practice had attempted to book this training with the local CCG but places were oversubscribed and the training was pending. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (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.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, tissue viability (care of skin and soft tissue wounds), spirometry (measurement of air in the lungs and phlebotomy (taking blood). Those with extended roles seeing patients with long-term conditions such as asthma and diabetes 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. It 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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Hospital and clinic letters and discharge summaries were usually seen on the day of receipt and all were actioned within 2-3 days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were relatively low at 9.7% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to

Good

Are services effective?

(for example, treatment is effective)

follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings every three months to discuss patients with complex needs. For example, those with long term conditions and mental health problems. These meetings were attended by district nurses, social workers, specialist diabetic nurses and coordinators for the care of elderly patients. Decisions about care planning were documented in the electronic patient record. Staff felt this system worked well. The practice took part in ICP (Integrated Care Pilot) care planning and the GP attended multidisciplinary meetings once a month. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, we saw guidance for staff in the form of a flow chart of the process of assessing patients capacity to make decisions, and consent to treatment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions; patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

All patients over the age of 75 years had a named GP. The practice keeps a register of older patients who are vulnerable or housebound. Home visits were available for these patients as well as telephone consultation appointments. Patients who were discharged from hospital, who were unable to attend the surgery were visited by a GP at home, unless they were receiving a 'step down' service initiated by the hospital. Sixty seven per cent of older patients had received the seasonal flu vaccination, this compared to the national average of 73%. The patient records within this population group evidenced that older patients were having their needs met. Patients with mobility problems could be referred to a physiotherapist who offered sessions at the practice three times a month.

Annual health checks were undertaken for all patients with long term conditions such as diabetes, asthma, and cardiopulmonary disease are were invited to the practice for an annual health check with the practice nurse. The

Good

Are services effective?

(for example, treatment is effective)

practice has a higher than average incidence of patients with diabetes. The practice nurse specialised in diabetes and had undertaken training for this role. The practice was able to refer patients with diabetes to a local 'one stop shop' diabetic clinic. The specialist diabetic nurse had also attended meetings with clinical staff to review patient care and offer advice on good practice. Seventy per cent of patients on the diabetic register had received their annual influenza vaccination in comparison the national average of 93%.

The practice offered antenatal care, six week mother and baby checks and childhood immunisations. Patients could book an appointment with the practice nurse for these services. Ninety four per cent of children under two had received their childhood immunisations, with 100% of children under five receiving the full range of immunisations. One hundred per cent of children who had moved to the United Kingdom from abroad had received their hepatitis B vaccination. Staff informed us that in the case of a child from abroad not having an immunisation record they were offered the full range of childhood immunisations.

We saw evidence of referral to specialist services for children. For example, to CAMHS (children and adolescent mental health services) as a result of assessment and consultation with the family. Staff at the practice met every three months to discuss children who were on the child protection register.

Extended hours were available on Monday, Tuesday and Wednesday until 7:15pm for patients who were not able to see their GP during normal working hours. Extended appointments were available with the practice nurse on Monday until 7:15. Nine GP telephone consultations were available daily.

It was practice policy to offer a health check 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.

The practice performance for the cervical screening programme was 69% which was below the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice acknowledged attendance was low and thought this may be due to cultural and religious reasons. We were informed that it was not unusual for cervical screening to be declined by female patients.

The practice held a register of patients who had a learning disability. All patients with a learning disability had an annual review and health check with their GP. The practice also held a register of patients who had dementia 97% of whom had been reviewed in the last twelve months and had an agreed documented care plan.

One of the GPs at the practice had a special interest in mental health and had also worked within a mental health setting. As a result of this patients with mental health illness at the practice were referred to this GP by other GPs in the practice. Patients in this category had a care plan and an annual review.

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 2014 and survey of patients undertaken by the practice's patient participation group (PPG) which had approximately 20 respondents. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated their experience of making an appointment as good. The practice was also rated above average for finding receptionists at the practice helpful; 90% of respondents said they found reception staff helpful in comparison to the CCG average of 84% and the national average of 87%. Information from the national patient survey also told us that 83% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%. Ninety five percent said the GP gave them enough time compared to the CCG average of 93% and the national average of 95 %.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff were supportive and treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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. Limited space was available for the reception and patient waiting area. Information was available on the practice web site regarding patient privacy at reception. Patients were requested to allow patients at reception sufficient space to facilitate. private/confidential communications with the reception staff. A separate room was available for patients who requested a private conversation with 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 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83%. Eighty two percent said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 82%.

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients commented that staff explained their treatment options and involved them in decisions and they felt they received the appropriate treatment.

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

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG

Good

Are services caring?

average of 78% and national average of 82%. Seventy nine per cent said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 98%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 had a high level of patients with diabetes. To assist patients to manage their diabetes one of the practice nurses was the lead in this area and had received training. The practice also worked with a specialist diabetic nurse from a local community team. The specialist nurse visited the practice to work with patients and clinicians.

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). The practice had conducted a survey in 2013/14. There were two parts to the survey which were, assessing patients knowledge of the appointment system and services available, and general feedback about the practice. As a result of the feedback an action plan had been developed and changes made. The appointment system had been changed with the option of pre bookable and telephone consultations. Prior to this the practice operated a walk-in only appointments system which was not suitable for some sections of the patient population group.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The staff were aware of patients who were vulnerable and needed immediate access to a GP. These patients were offered same day appointments or telephone consultations.

The majority of the practice population were Somali, Gujarati and Arabic speaking patients. Access to online and telephone translation services were available if this was needed by patients. there were male and female GPs in the practice; allowing patients to choose the gender of the doctor they saw.

The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. The practice had a separate shelter outside for prams. This made movement around the practice easier and helped to maintain patients' independence.

Access to the service

The practice operated a walk in system every weekday morning whereby patients could walk in between 8:45am to 10:15am and were seen on a "first come first served basis." The practice closed at approximately 12:45pm and opened at 4:45pm for evening surgery. From Monday to Wednesdays, evening appointments were pre-booked from 5pm to 7pm. On Thursdays the practice operated the same morning walk in, but remained closed after 12:45pm. On Fridays, the surgery closed at 12:45pm and reopened again for pre-booked appointments from 4:30-6:30pm.

Information was available to patients about opening and appointment times on the NHS Choices website. There were also arrangements 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 also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available for patients who were not in the position to visit the practice and some patients who had been discharged from hospital.

The patient survey information we reviewed showed patients generally rated the practice well in these areas. For example 69% were satisfied with the practice's opening hours compared to the national average of 79%. Seventy eight per cent described their experience of making an appointment as good compared to the CCG average of 68% and national average of 74%. Forty two per cent said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 50% and national average of 65%, and 76 % said they could get through easily to the surgery by phone compared to the CCG average of 70% and the national average of 74 %.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They

Good

Are services responsive to people's needs?

(for example, to feedback?)

confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Patients said the appointments system suited them with some commenting that they preferred walk-in appointments and others preferring to pre book their appointment.

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. The complaints procedure was included in the practice information leaflet and included the name of the member of staff to contact to raise a complaint or concern. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found that these were handled in a satisfactory manner and we were able to see the action the practice had taken as a result of these complaints. We viewed the minutes of staff meetings and saw that patient feedback and complaints were discussed. The practice had produced information posters for the waiting area in English and Somali as the result of a complaint about time allocated for each consultation.

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

The practice had a vision to deliver high quality care and promote good outcomes for patients. The practice was going through a transitional period due to the sudden departure of a GP from their post at the practice. The GP had worked at the practice for a significant number of years and staff explained how it had been necessary to support patients to manage this change. We spoke with six members of staff and they all knew and understood the vision and values of the practice. Staff said they had to rebuild practice morale due to this event, and improve management systems and outcomes for patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five of these policies, including the clinical governance policy which set out how the practice aimed to improve outcomes for patients and ensure their safety and wellbeing.

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 the senior partner 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 GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example in the areas of infection control and fire safety. The practice monitored risks on a monthly basis to identify any areas that needed addressing; this was evidenced in staff meeting minutes. We looked at the minutes from these meetings and found that performance, quality and risks had been discussed. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, the clinical governance policy and recruitment policy, which were in place to support staff.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every two months. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed

Are services well-led?

Good

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

from these surveys are available on the practice website. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing and had changed the appointment system as a result of their findings. The most recent PPG survey we viewed was for 2013/2014, the survey available on the practice website was for 2012.

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 four staff files and saw that regular appraisals took place which included a personal development plan. One file did not contain evidence of an annual appraisal as the member of staff had employed at the practice for under a year. Staff told us that the practice was supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. As a result of these reviews

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not have adequate arrangements in place to ensure that staff undertook training in child protection and safeguarding adults to enable them to fulfil the requirements of their role. This was in breach of regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: People who use services were not fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post. This was in breach of regulation 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.