

# Dr Raphael Rasooly

## Quality Report

Neasden Medical Centre  
21 Tanfield Avenue  
London  
NW2 7SA  
Tel: 020 8208 0306  
Website: -

Date of inspection visit: 30 October 2014  
Date of publication: 05/03/2015

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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Requires improvement



# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

### Detailed findings from this inspection

Our inspection team	10
Background to Dr Raphael Rasooly	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12
Action we have told the provider to take	22

## Overall summary

### Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr Raphael Rasooly, also known as Neasden Medical Centre. The practice is registered with the Care Quality Commission to provide primary care services.

We carried out a comprehensive inspection on 30 October 2014. We spoke with patients and staff, including the management team.

The practice is rated as 'requires improvement' for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including all the population groups. We gave the practice an overall rating of 'requires improvement'.

Our key findings were as follows:

- Procedures were in place to report and record safety incidents
- The practice used up to date best practice guidance to ensure good outcomes for patients

- The practice met with local providers to share best practice and improve patient outcomes
- Patients found it easy to access the service and make an appointment
- Patients said they were treated with kindness and respect

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

Importantly, the provider must:

- Have a system to regularly assess and monitor the quality of the service, and manage risks relating to the health and safety of patients and staff.
- Ensure that the appropriate pre-employment checks are carried out before staff commence work at the practice. Ensure that all staff acting as chaperones have had a Disclosure and Barring Service check.
- Ensure that confidential information is stored securely.

In addition the provider should:

# Summary of findings

- Keep records to show that learning from serious events, safety incidents, complaints, and feedback is shared with staff.
- Provide relevant staff with chaperone training and make patients aware they can request a chaperone during their consultation.
- Carry out a legionella risk assessment to identify and monitor the risks associated with legionella bacteria.
- Complete audit cycles to monitor and improve quality of care.
- Formalise their vision and values and share these with patients and staff.

**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?

The practice was rated as requiring improvement for providing safe services as there were areas where improvements must be made. Procedures were in place to report and record safety incidents. Staff demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. However, the practice did not have formal procedures for documenting meetings or demonstrating how learning was shared with staff. Whilst there was a system to highlight vulnerable patients and all clinical staff had received training in child protection and safeguarding vulnerable adults, some staff had not received updated training. We did not see comprehensive risk assessments in areas such as health and safety, fire safety, and to identify and monitor the risks associated with legionella bacteria. Some confidential information was not stored securely. Recruitment checks, such as Disclosure and Barring Service checks and references, had not been obtained for some staff. The practice also did not record when medicines and emergency equipment were checked for stock control and expiry.

Requires improvement



### Are services effective?

The practice was rated as requires improvement for providing effective services, as there were areas where improvements should be made. Clinicians were up-to-date with National guidelines, and we saw evidence that confirmed these guidelines were being utilised to improve outcomes for patients. Staff networked with other local providers to share best practice and improve patient outcomes. The practice regularly met with other health professionals to coordinate care. Whilst staff received support to develop in their roles, the practice did not always have records to show staff learning and progression was monitored and evaluated. Clinical audits were undertaken, however the practice could not demonstrate completed audit cycles to monitor and improve the quality of care.

Requires improvement



### Are services caring?

The practice was rated as requires improvement for providing caring services, as there were areas where improvements should be made. We observed a patient centred culture. Most patients we spoke to provided positive feedback and said that staff treated them with care and respect. However, this was not always reflected in data from the National GP Patient Survey, where patients rated the practice lower than others in the local area for some aspects of care.

Requires improvement



# Summary of findings

The practice had not taken action to review or address this. Information was not always available to help patients understand the services available to them, such as being able to speak with staff members in a private area or requesting a chaperone.

## Are services responsive to people's needs?

The practice was rated as requires improvement for providing responsive services. Feedback from patients revealed that access to the practice was good and urgent appointments were usually available the same day. However some patients commented that it took a lengthy time to book an appointment with a female GP. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain however, the practice did not keep records to show that learning from complaints and feedback had been shared with staff or patients.

**Requires improvement**



## Are services well-led?

The practice was rated as requires improvement for being well-led. Senior staff were able to describe a vision and strategy, but this had not been formalised and shared with staff or patients. There was a leadership structure and staff felt supported by management. However, staff meetings, evaluation and learning were not always documented. The practice had a number of policies and procedures to govern activity, but a few of these required updating. The practice was conducting a survey, but they had yet to review the results.

**Requires improvement**



# 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

The practice was rated as requires improvement for the care of older people. All patients over the age of 75 had a named GP. The GPs attended monthly multidisciplinary meetings to discuss patients' care plans. The practice worked with other healthcare providers to coordinate patient care, and support older people deemed at risk of admission to hospital or residential care. Joint home visits with the district nurses were carried out for older patients identified as at risk. Home visits and telephone consultations were also available for patients who required them, including housebound patients, and patients in nursing homes and sheltered accommodation. Flu vaccines were offered to older patients in line with current national guidance, and staff were proactive in reminding patients about this.

The practice was rated as requires improvement for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



### People with long term conditions

The practice was rated as requires improvement for the care of people with long term conditions. There was a lead GP for chronic disease management. The nurse performed diagnostic screening, such as electrocardiograms, for patients taking specific medicines for chronic conditions. Scheduled appointments to develop integrated care plans were offered to patients who were identified as 'at risk', including patients with palliative care needs and multiple long-term conditions. The practice also engaged in regular meetings with a multidisciplinary team to discuss the care and support needs of patients receiving palliative care and patients with complex needs.

The practice was rated as requires improvement for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



### Families, children and young people

The practice was rated as requires improvement for the care of families, children and young people. A baby clinic was run every week, with the opportunity for patients to see the GP and

**Requires improvement**



# Summary of findings

immunisation nurse on the same day. There was a lead GP for antenatal and postnatal care, and longer appointments were booked for these check-ups. Appointments were also available outside of school hours.

The practice was rated as requires improvement for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

## **Working age people (including those recently retired and students)**

The practice was rated as requires improvement for the care of working age people (including those recently retired and students). The practice offered extended opening hours for appointments from 07:00-08:00 Monday to Thursday. Patients could book appointments online and order repeat prescriptions online. Health checks were offered to new patients registering with the practice, and the NHS Health checks were available to patients aged 40-74. Health promotion advice was also offered during consultations, but there was limited accessible health promotion material available through the practice.

The practice was rated as requires improvement for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**



## **People whose circumstances may make them vulnerable**

The practice was rated as requires improvement for the care of people whose circumstances may make them vulnerable. There was a system to highlight vulnerable patients on the practice's electronic records. The practice held a register of patients with learning disabilities, and longer appointments were offered to these patients. The practice had signed up to enhanced services for patients with learning disabilities, and was carrying out annual health checks for these patients. GPs had undergone further training in the treatment of patients with learning disabilities. There was a system in place for identifying carers, and these patients were offered health checks and immunisations. Referrals were also made to support services so that carers could access further information and support. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. Although staff knew how to recognise signs of abuse in vulnerable adults and children, some non-clinical staff had not received updated safeguarding training.

**Requires improvement**



# Summary of findings

The practice was rated as requires improvement for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

## **People experiencing poor mental health (including people with dementia)**

The practice was rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were screened by the GPs and the practice made referrals to local mental health teams. The practice had taken into account the needs of patients with dementia and adapted their prescriptions so that patients could manage their medicines more easily. Referrals were also made to emotional support services and outreach teams, and information on these services was made available for patients.

The practice was rated as requires improvement for the service being safe, effective, caring, responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

**Requires improvement**





# Summary of findings

## What people who use the service say

We spoke with seven patients during our visit. We reviewed comments from 32 Care Quality Commission (CQC) comment cards which had been completed, and data from the National GP Patient Survey 2014.

Patients we spoke with were happy with the cleanliness of the environment and the facilities available. Most patients said staff were caring and treated them with dignity and respect. We were told that staff listened patiently to patients' needs and treated them in an efficient and considerate manner.

Most patients commented that the opening hours were suitable for their needs, however some patients expressed that they could not easily get an appointment with a female GP.

The comment cards reviewed were mostly positive and patients wrote that staff were kind and helpful. Patients commented that they were included in discussions in relation to their care, and that staff understood their problems.

Data from the National GP Patient Survey 2014 showed that 76% of respondents found the overall experience of the practice good, which was marginally below the regional average. The practice scored particularly well in patients accessing the practice and their experience of making an appointment. Areas where the practice scored lower than the regional average included patients' interactions with the GPs and nurses. These focused on the patient being involved in decisions about their care, and staff explaining tests and treatments to the patient.

## Areas for improvement

### Action the service **MUST** take to improve

- Have a system to regularly assess and monitor the quality of the service, and manage risks relating to the health and safety of patients and staff.
- Ensure that the appropriate pre-employment checks are carried out before staff commence work at the practice. Ensure that all staff acting as chaperones have had a Disclosure and Barring Service check.
- Ensure that confidential information is stored securely.

### Action the service **SHOULD** take to improve

- Keep records to show that learning from serious events, safety incidents, complaints, and feedback is shared with staff.
- Provide relevant staff with chaperone training and make patients aware they can request a chaperone during their consultation.
- Identify and monitor the risks associated with legionella bacteria.
- Complete audit cycles to monitor and improve quality of care.
- Formalise their vision and values and share these with patients and staff.

# Dr Raphael Rasooly

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Advisor and a Practice Manager Specialist Advisor. They were granted the same authority to enter the registered persons' premises as the CQC inspector.

## Background to Dr Raphael Rasooly

Dr Raphael Rasooly, also known as Neasden Medical Centre, provides GP led primary care services to around 4,800 patients living in the surrounding areas of Neasden, Edgware, Kingsbury and Colindale, in the London Borough of Brent. The practice holds a General Medical Services (GMS) contract with NHS England for delivering primary care services to the local community. The practice has a higher proportion of patients between the ages of 20-39, when compared with the England average. The number of patients over the age of 60 is lower than the England average.

The practice has a male GP principal, a female assistant GP, a female salaried GP, and a male GP locum. Other staff include a nurse, a health care assistant, two phlebotomists who also cover reception, a practice manager, and a small team of reception and administration staff. A practice nurse, employed by another healthcare provider, offers immunisations every Wednesday afternoon for three hours. The GP principal works 30 clinical hours per week, the assistant GP works five clinical hours per week and covers extra hours dependent on staffing levels, the salaried GP works eight hours, and the GP locum covers sessions as

required. The nurse works 10 clinical hours plus 30 management hours, and the immunisation nurse works five hours per week. The health care assistant and phlebotomists divide their clinical and administrative hours based on patient demand.

The practice is located in a converted residential property. The opening hours are 08:00 – 18:00 every weekday except Thursday afternoons, when the practice closes at 13:00. Extended hours are offered with the GPs from 07:00 to 08:00 Monday to Thursday. The practice opted out of providing out-of-hours services to their patients. Outside of normal opening hours patients are directed to an out-of-hours service or the NHS 111 service. Patients can also be seen at a local hub which provides primary care services to patients within the locality, with additional evening and weekend hours available.

Neasden Medical Centre has a sister practice called Greenhill Park Medical Centre. Some staff work across both sites, and patients have the option of attending either site.

## Why we carried out this inspection

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

- Is it safe?

# Detailed findings

- 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 our inspection we reviewed a range of information we hold about the practice. As part of the inspection process we contacted key stakeholders which included Brent Clinical Commissioning Group (CCG) and Brent Healthwatch, and reviewed the information they shared with us.

We carried out an announced inspection on 30 October 2014. During our inspection we spoke with a range of staff including: the assistant GP; practice manager; nurse; health care assistant/administrator; and a receptionist. We observed how patients were being cared for and sought the views of patients. We spoke with seven patients on the day of our inspection. We reviewed 32 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

# Are services safe?

## Our findings

### Safe track record

The practice had procedures in place to report and record safety incidents, including concerns and near misses. We saw that incidents had been recorded since 2010. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. They told us there was an individual and shared responsibility to report and record matters of safety. Staff described a recent incident involving a patient who had collapsed in the waiting room. The patient was cared for and escorted home by practice staff. We saw the incident had been documented in the incident book and within the patients' electronic record.

National patient safety alerts were received electronically by the GPs, and concerns were addressed in a timely manner. A GP provided an example of a recent safety alert relating to the prescribing of a combination of two medicines. In response to the alert, the information was relayed to administrative staff who identified and recalled patients taking these medicines. The GPs reviewed these patients and amended their medicines as a result.

### Learning and improvement from safety incidents

The practice recorded significant events, and the practice manager informed us that there had been one significant event within the last 12 months. A description of the incident, outcome, analysis and learning achieved were documented. The example we reviewed involved an inappropriate urgent referral being made for a patient who was already under the care of a hospital consultant. The learning as a result of the analysis was that the practice should follow-up referrals where no discharge letter from the hospital had been received.

The practice did not have records to demonstrate that incidents and learning was shared with staff. We saw GPs had recorded serious events in their annual GP appraisal, but they told us learning was shared informally with clinical staff and these conversations were not documented. We spoke to staff, who confirmed that informal discussions about significant events took place. Administrative staff had weekly meetings to discuss improvements from safety incidents, however there were no minutes to these meetings. Staff we spoke with aware of their responsibilities in reporting significant events, and told us that learning was shared informally on a weekly basis.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children and adults.

There were procedures for escalating concerns and receiving feedback from the relevant protection agencies for child protection such as the multi-agency safeguarding hub (MASH), however the practice's policy had not been updated with the contact details for the MASH. The policy for safeguarding vulnerable adults also required updating with the contact details for the local safeguarding adults team.

There was a system to highlight vulnerable patients on the practice's electronic records system, and we saw evidence that vulnerable patients had been coded and appropriate referrals had been made. The GP principal was the practice lead for child protection and safeguarding vulnerable adults, and had received Level 3 child protection training to enable them to fulfil this role. All GPs and the nurse were up to date with training in child protection and safeguarding vulnerable adults. Other staff had not received training or required updated training, and we saw the practice had made arrangements for this to take place. Staff knew who the safeguarding leads were, how to recognise signs of abuse, and how to escalate concerns within the practice.

A chaperone policy was in place and staff understood their role and responsibilities when acting as a chaperone. However, there were no notices to inform patients that they could request a chaperone, and staff who acted as chaperones had not received a Disclosure and Barring Service check (DBS).

### Medicines management

The practice manager was the lead for medicines management. Arrangements were in place to ensure medicines kept at the practice were stored securely and only accessible to authorised staff. The practice had documented procedures for maintenance of the cold chain with actions to be taken in the event of any potential failure. Staff had good awareness of the processes to follow and were aware of what to do if the cold chain was compromised. We saw records to confirm fridge temperatures were checked daily. Individual staff members were responsible for ordering and monitoring medicines to check they were within their expiry date, suitable for use, and that there was sufficient stock. However, the practice did not have formal records to show medicines were

## Are services safe?

monitored for stock control and expiry dates. All the medicines we checked were within their expiry dates and there was evidence of stock rotation to ensure older stock was near the front of the fridge. Staff told us that expired and unwanted medicines were disposed of by the pharmacy.

The GP principal was the lead for prescribing, and we reviewed prescribing audits conducted in conjunction with the local clinical commissioning group. Administrative staff who generated authorised repeat prescriptions were able to describe their duties in line with the legal framework. They told us if a requested prescription was not up to date, they would book an appointment for the patient to have a review with the GP. Prescriptions requested in discharge letters from hospital consultants, and repeat prescriptions for controlled drugs were always reviewed by the GPs prior to being issued. The practice had taken into account the needs of patients with dementia by adapting their prescriptions for dosette boxes, to ensure patients did not become confused or mismanage their medicines. Blank prescription forms and uncollected prescriptions were kept securely at all times. Patients could request repeat prescriptions in person, online or via post, and these took 48 hours to process. It was the practice's policy not to accept orders over the phone for safety reasons. A notice in the reception area notified patients of this process.

There was a system in place for the management of patients taking high risk medicines such as warfarin and methotrexate. Blood test results were monitored before prescriptions were issued, and we saw evidence that this had been clearly documented in patients' electronic records.

Vaccines, including childhood immunisations, were administered by a practice nurse employed by another healthcare provider. We saw directions that had been produced in line with legal and national guidance were in place. During busy periods such as the flu season, the GPs and nurse were available to administer the flu vaccine.

### Cleanliness and infection control

The practice was visibly clean and tidy. Cleaning schedules and rotas were in place, and we saw these records were kept up to date. Signs reminding staff of good hand hygiene techniques were displayed by hand washing sinks, along with soap, hand gel and hand towel dispensers.

Personal protective equipment was available in all clinical rooms. Patients told us that the practice looked clean, and they had no concerns about cleanliness or infection control.

The GP principal was the lead for infection prevention and control and had received training. Most staff had received training, and we were told that the nurse provided further staff training in areas such as specimen handling and hand washing techniques. Staff confirmed they had received recent infection prevention and control training with the nurse.

An infection control audit had been carried out in May 2014. Areas for improvement were identified, and the practice had taken action to address some of these areas. For example, cleaning schedules had been implemented, and staff had received training. Some recommended actions from the audit remained outstanding, such as the replacement of a small sink, however the practice had managed the issue of overflow and the sink and surrounding area were kept clean and tidy. The practice had yet to complete a legionella risk assessment to identify and monitor the risks associated with legionella bacteria.

There was no specimens handling policy, however staff were able to describe their actions to implement infection control measures when receiving specimens from patients.

### Equipment

Staff told us they had sufficient equipment to carry out their roles in assessing and treating patients. Equipment had been tested and calibrated in March 2014, and we saw records to confirm this for items such as blood pressure monitors and weighing scales. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was October 2014.

### Staffing and recruitment

The practice had a recruitment policy that set out the standards it should follow when recruiting staff, however we found the practice had not always adhered to their own policy. The recruitment policy referred to recruitment checks to be undertaken for new staff prior to employment, such as proof of identification, two references, qualifications, registration with the appropriate professional body, and a criminal records check via the Disclosure and Barring Service (DBS) when appropriate. We reviewed six staff recruitment files and found that application forms with past employment history and

## Are services safe?

references had not been obtained for these staff. We were informed that most of these staff had been employed for a number of years, however we saw records which confirmed that one member of staff who was newly employed in 2013 did not have references. The practice had also not conducted DBS checks for the nurse, health care assistant, and one receptionist who acted as a chaperone. The practice manager was aware of this and told us the relevant checks would be arranged. We were told all new staff underwent a general induction and this was documented in the recruitment policy, however there were no induction records for the newest member of the practice.

There was no documented rota system for clinical staff, however the practice manager described the arrangements for when clinical staff were absent. When the GP principal was on leave, the assistant GP and a regular GP locum covered these clinical sessions. If the nurse was on leave, the GPs covered some aspects of the nursing service, including wound care, and the health care assistants assisted with phlebotomy. A rota system was in place for reception staff.

### Monitoring safety and responding to risk

There were some systems in place to monitor and respond to risks within the practice, but some areas required improvement. Health and safety policies were in place and there were posters on display with information relating to health and safety in the workplace. We saw evidence that equipment was checked regularly, the boiler had been serviced, and a business continuity plan was in place. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the practice manager if an accident occurred. The practice manager informed us that incidents were shared weekly during informal staff meetings. There were some areas that required improvement. Some staff had received training in health and safety, however two newer members of staff had yet to complete training. Staff informed us that no health and safety risk assessments were routinely carried out. Records showed that fire safety had not been assessed since 2010. Staff told us a fire drill was carried out a year ago, but this had not been documented.

The practice kept paper and electronic patient records. Electronic records were password protected and could only

be accessed by staff. Patients' paper records were stored in a designated room and behind reception. We saw the storage room door was closed and could be locked for security. The reception could be locked overnight, however the records in reception were kept on open shelving and were not stored securely. We observed an external contractor working on a computer at the back of reception and although the front of reception was always attended by reception staff, the back area where some records were kept was concealed by shelving. We also observed patient confidential information, such as prescriptions and referral letters being left in a consultation room with the door open prior to the arrival of clinical staff. This room could be assessed by patients waiting in the area adjacent to the reception.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records confirmed all staff had received training in basic life support. Emergency equipment was available including oxygen, an automated external defibrillator (used to attempt to restart a person's heart in an emergency), and resuscitation equipment. Staff informed us that the emergency equipment was checked monthly however, there were no records to confirm this.

Emergency medicines were also stored with the emergency equipment. There was a list detailing what medicines should be present and when they expired, however these records had not been updated. For example, the medicines stock list showed that a medicine had expired, however when we checked the medicine it had already been changed and was within its expiry date. All the medicines we checked were in date and suitable for use. Staff we spoke with knew where the emergency equipment and medicines were located.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of medical records, failure of telecommunications, and incapacity of senior staff. The plan contained relevant contact details for staff to refer to, such as contact details for utility providers in the event of failure to services such as the electricity or gas supply.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GP assistant and nurse were familiar with and followed National Institute for Health and Care Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) guidance around treatment and prescribing. Clinical staff provided examples of when routine diagnostic screening, such as blood tests and electrocardiograms, were performed in line with NICE guidelines for patients on specific medicines.

The GP told us there were leads in specialist clinical areas such as diabetes, minor surgery, and ophthalmology, 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. For example, the nurse told us the support she received assisted her to review and discuss best practice with the GP principal.

The GP principal, practice manager and nurse attended monthly network meetings with 26 practices in their locality group, and the GP principal attended monthly Clinical Commissioning Group (CCG) meetings. The purpose of these meetings was to discuss current best practice in primary care, and changes in the community relevant to service providers. We saw minutes to the recent meetings attended by the practice staff. The practice manager also attended monthly meetings specifically for practice managers in Brent. These meetings allowed practice managers to talk about local schemes, and share difficulties they may be facing.

### Management, monitoring and improving outcomes for people

Delivery of care and treatment achieved positive outcomes for people. We reviewed the most recent Quality and Outcomes Framework (QOF) scores for the practice. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. The practice's score for the clinical domain was 592 out of 610. Their overall achievement was 863 out of 900, which was above the regional and national average.

The GPs undertook clinical audits. We reviewed audits relating to medicines management, such as reviewing patients on 12 or more medicines. Another example included the variation of vitamin D prescribing in ethnicity

groups. The audit showed lower vitamin D levels in particular ethnic groups and as a result the practice now checked vitamin D levels for these patients. However, audit cycles were incomplete, in that the audits had not been repeated to assess if performance had improved.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff had received training in areas such as basic life support, infection control, and safeguarding. However, there was no training schedule to monitor when staff training required updating. As a result, some staff had not received up-to-date safeguarding training.

There was evidence that some staff had additional qualifications to support the needs of the local population. For example, the GP principal had postgraduate diplomas in Ophthalmology and Diabetes, the practice manager was a qualified health care assistant, and a receptionist had also trained as a phlebotomist. A specialist immunisations nurse was also commissioned to provide immunisations on a weekly basis.

We saw the GPs kept up to date with continuing professional development. One GP had received their annual appraisal, and two were awaiting their appraisal for this year. The fourth GP was newly qualified and due for appraisal next year. Two GPs had undergone revalidation in 2014, and the other two GPs were awaiting a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation.

We were told that all staff had annual appraisals which identified personal development. One member of reception staff told us they had undergone their appraisal this year, however the appraisal documentation was not present in the staff member's training file. We reviewed another two files for administrative staff and found one contained an appraisal for this year, and the other did not. The nurse was due for appraisal next year.

The practice had a training policy and staff had opportunities for professional development beyond mandatory training. Staff told us that the practice was supportive in providing training opportunities relevant to their role. For example, a health care assistant had undergone a course in phlebotomy. The practice's training

# Are services effective?

## (for example, treatment is effective)

policy and recruitment policy made reference to an induction process for new staff. We viewed the training file for a newer member of staff who joined in 2013, but did not see documentation for their induction period.

### Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, both electronically and by post. Information from out-of-hours GP services and the NHS 111 service were received via fax. The GP who saw these documents and results was responsible for the action required. There were no recorded incidents where communications had not been followed up.

The practice worked with other healthcare providers to coordinate patient care. The practice was commissioned for enhanced services for unplanned admissions, and worked with the integrated care coordination service (ICCS) to support older people deemed at risk of admission to hospital or residential care. Monthly meetings involving the ICCS and other external agencies, such as the district nursing team, were carried out to ensure care plans received multidisciplinary input. We reviewed the care plan of a patient with chronic obstructive pulmonary disease (COPD). It was evident that the GP had attended monthly meetings with the COPD team to monitor the ongoing assessment of the patient, home visits had been arranged with the district nurses, and the patient's care plan from 2013 had been reviewed and updated this year.

### Information sharing

Clinical staff were responsible for their own referrals and letters, and electronic systems were in place for making these referrals. Most referrals were sent to a central referral centre to check they were appropriate. The practice had direct referral links with a local hospital for specialist cardiology services. Some urgent referrals, such as those under the two week wait, were faxed directly to the hospital and reception staff would follow-up to confirm receipt of the referral. The GP told us this protocol was put in place following an incident where the hospital did not receive an urgent referral. We saw examples of referrals where staff had phoned the hospitals to confirm receipt, and then updated the patient with their appointment details.

If the practice were full to capacity and unable to see a patient during their opening hours they could fax a referral

to the Hub service, who were a another local primary care provider open until 20.00 on weekdays and during the weekend. After seeing the patient the Hub service would fax a discharge summary to the practice, informing them of the treatment undertaken for the patient.

An electronic patient record, EMIS, was used by all staff to coordinate, document and manage patients' care. The practice had signed up to the electronic Summary Care Record, which provided staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

### Consent to care and treatment

Clinical staff we spoke with had knowledge of the Mental Capacity Act 2005 and the Children's and Families Act 2014. Staff were aware of when they may need to assess mental capacity. There was a clinical lead for learning disabilities and we saw evidence that clinical staff had undergone training in learning disabilities.

Care plans for patients with learning disabilities were reviewed annually, or if there was a change in the patient's health. We saw records which confirmed a GP had actively contacted a patient and conducted their annual review. Data showed that all six patients on the learning disability register had their annual physical health checks and care plan reviewed this year. Clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. The GPs described recent examples where they had to assess capacity and gain consent from children, and we saw this was clearly documented within patients' records.

### Health promotion and prevention

All new patients registering with the practice were offered a health check with the nurse. If patients had complex health conditions they were followed-up by the GPs at a later date. The GPs also identified current patients, including those with chronic conditions, who required health checks. NHS Health Checks were also available to patients aged 40-74. However, there was no information for patients advertising that health checks were available.

The practice also used opportunistic health promotion and prevention, with prompts set-up on the computer system to assist clinicians with this. A blood pressure pod, weighing scale, and height measure were available in an



# Are services effective?

(for example, treatment is effective)

area away from the waiting room for patients to utilise. We observed reception staff assisting patients with blood pressure monitoring, and inputting the results on to the patients' records so that they were readily available for the GP to view during the consultation.

The practice had an electrocardiogram (ECG) machine which automatically uploaded results onto the computer system. Staff told us that routine screening was performed for patients taking specific medicines. We saw an example of a recent ECG test which had been saved to the patient's medical records. The practice had direct referral links with a local hospital if specialist cardiology services were required.

The practice's performance for cervical smear uptake was 51%, which was below their 80% target. The practice had

since recruited a female GP to assist with undertaking smear tests. The practice also referred patients to sexual health clinics in the local area as they provided extended opening hours which patients found convenient.

A baby clinic was run every week, with the opportunity for patients to see the GP and immunisation nurse on the same day. The practice offered a range of immunisations including childhood immunisations, travel vaccinations and flu vaccinations in line with current national guidance. We observed reception staff reminding patients about the flu vaccine, and saw two patients being booked for their flu vaccination the same day.

The practice made referrals to an outreach and engagement service, who provided support for people with drug and alcohol problems. We saw posters advertising the outreach service and information for patients to take away.

# 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 GP Patient Survey 2014, where the survey completion rate was 27%. Data showed that 76% of respondents found the overall experience of the practice good, which was marginally below the regional clinical commissioning group (CCG) average of 78%. Seventy-three per cent of respondents said the GP was good at listening to them, which was below the CCG average of 84%. Sixty-seven per cent of respondents said the GP was good at treating them with care and concern, which was lower than the CCG average of 78%. Satisfaction scores on consultations with the nurses were also below the regional average. Sixty-eight per cent of respondents said the nurse was good at listening to them, compared to the higher CCG average of 74%. Sixty-four per cent of respondents said the nurse treated them with care and concern, which was below the CCG average of 72%. The practice had yet to review the data from the National GP Patient Survey 2014, but were planning to do so.

We received 32 CQC comments cards where patients shared their views and experiences of the service. The majority of comments were positive. Most patients said staff treated them with dignity and respect, and were caring, helpful, and kind. Some patients said staff listened patiently to their needs and treated them in an efficient and considerate manner.

The reception area where patients checked-in for their appointment was within the general waiting room, and there was little privacy for patients to speak with staff. Reception staff told us that they could speak with patients confidentially in an area away from the waiting room, or in a consulting room if required. However, patients we spoke with were not aware of this and we did not see any notices informing patients about it.

### Care planning and involvement in decisions about care and treatment

Results from the National GP Patient Survey 2014 showed that 64% of respondents found their GP was good at involving them in decisions about their care, which was below the CCG average of 72%. Sixty-eight per cent of

respondents said the GP was good at explaining tests and treatments, which was also below the regional average of 80%. Results for the same interactions with nursing staff showed 51% of respondents stated the nurse was good at involving them in decisions about their care, which was lower than the CCG average of 65%. Sixty-five per cent of respondents said the nurse was good at explaining tests and treatments, which was also lower than regional average of 73%. The practice should take action to review or address this.

Patients we spoke with responded positively to questions about their involvement in planning and making decisions about their care and treatment. They told us they felt listened to and involved during consultations with the GPs and nurse. The CQC comment cards were also positive with patients stating they were included in discussions regarding their treatment options, and that staff understood their problems and made appropriate referrals in a timely manner. During our visit we observed reception staff booking hospital appointments for patients and offering patients a choice of where they would like to attend.

Scheduled appointments to develop integrated care plans were offered to patients who were identified as 'at risk', including patients with palliative care needs and multiple conditions. Annual health check reviews were offered throughout the year for patients with learning disabilities, and we saw evidence that since April 2014 the practice had completed these health checks for the six patients on the learning disability register.

### Patient/carer support to cope emotionally with care and treatment

The practice made referrals to emotional support services such as Improving Access to Psychological Therapies (IAPT) and bereavement services. Patients experiencing poor mental health were screened at the practice and the GPs had referral links with the local mental health team. Staff told us that where there was a decline in a patient's mental cognition, referrals to the local memory clinic were made.

The practice had a carers policy and there was a system in place for identifying carers. Staff were aware of patients' needs and told us that carers were offered health checks. Referrals were also made to Brent Carers Association so patients could access further support and information.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The needs of the practice population were understood. The GP principal, practice manager and nurse attended networking meetings with practices in the local area. The aim of these meetings was to discuss the needs of the local population, and we saw minutes of recent meetings attended by staff. The practice also contributed to the networking meetings, and we saw a recent presentation given by the practice manager and nurse on the 'unplanned admissions enhanced service'.

The GP principal was male, and patients could access a female GP three days a week. Routine appointments with the GPs were 10 minutes, and the practice offered longer appointments for postnatal check-ups and for patients who might require them, including patients with learning disabilities. Home visits and telephone consultations were also available to patients who required them, including housebound patients, and patients in nursing homes and sheltered accommodation.

The assistant GP led on antenatal and postnatal care, and a weekly clinic was jointly offered with the health visiting team for mother and baby checks. A practice nurse employed to carry out immunisations was also available on a weekly basis.

The practice had a palliative care register, and staff told us these patients were discussed with the district nurse every fortnight. The practice also engaged in monthly multidisciplinary meetings to discuss the care and support needs of vulnerable patients and those with complex needs.

The practice had not signed up to the enhanced service to have a Patient Participation Group, and the practice manager informed us there were no immediate plans to organise one. The practice were in the process of conducting an in-house patient survey, and had yet to analyse the results of this. Most patients we spoke to told us the practice was meeting their needs. Where this was not the case, it referred to patients not being able to easily access a female GP and having to wait up to three weeks for an appointment with a female GP. We spoke to the practice manager about this and were told the practice had recruited a second female GP to improve access and the availability of appointments with a female GP.

### Tackling inequity and promoting equality

The practice recognised the needs of different groups of patients in the planning of its services. There was an equality and diversity policy in place, and staff were aware of how to access this policy. The practice had access to an interpreting service, and staff members spoke a variety of languages including Gujarati, Tamil, Hindi, Urdu, Hungarian, Italian, Punjabi, Polish, Russian, and Swahili. The list of languages spoken by practice staff was advertised on a sign outside the practice. We observed reception staff conversing with patients in different languages throughout the day.

All consulting rooms were based on the ground floor to assist people with mobility difficulties. There were no baby changing facilities, but staff informed us that a room would be offered to patients when required.

### Access to the service

The practice was open 08:00 – 18:00 every weekday except Thursday afternoons, when the practice closed at 13:00. Outside of normal opening hours patients were directed to an out-of-hours service or the NHS 111 service.

Appointments were pre-booked in person, over the phone, or online, and there were a number of emergency appointments available daily. We observed three patients who walked in and were offered an appointment the same day. The regular opening hours were provided in the practice leaflet, and there was a sign outside the practice notifying patients that the practice was closed on Thursday afternoons. Patients told us they could easily contact the practice to make an appointment. This was reflected in the National GP Patient Survey where 76% of respondents found it easy to get through on the phone, and 83% found their experience of making an appointment good. These scores were higher than the regional averages of 67% and 69% respectively.

Extended opening hours were available Monday to Thursday from 07:00 to 08:00. The early morning appointments were useful for patients who could not access the practice during working hours. Appointments outside of school / college hours were offered to children and young people. Staff told us that additional clinical sessions were occasionally offered on Thursday afternoons in response to patient feedback and demand. We observed these additional sessions taking place during our visit. Patients told us the opening hours were suitable for their

# Are services responsive to people's needs?

(for example, to feedback?)

needs. This was reflected in the National GP Patient Survey where 96% of respondents stated the last appointment they received was convenient, compared to the lower regional average of 87%.

If the practice was full to capacity and unable to see a patient during the day, they were able to refer patients to a Hub service which saw patients until 20.00 every evening. Some patients we spoke with had been referred to the hub service and told us they were seen the same day.

## Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England, and the practice manager was the designated responsible person who handled all complaints in the practice. Staff we spoke with were aware of the system in

place to deal with complaints, and told us they would try to diffuse any complaints and would then direct patients to the practice manager. There was a notice in the reception area informing patients of the complaints policy. The patients we spoke with had never made a complaint, but told us they would be comfortable to do so if required. Most patients told us they would approach the GP principal in the first instance.

The practice did not have a structured system to learn from concerns and complaints. There was a shared comments and prescriptions request box at the reception desk. The practice manager informed us that feedback was reviewed and discussed with staff on a weekly basis, but there were no meeting minutes to confirm this. We were informed that there had been one complaint this year, and we saw evidence that this was being followed up by an external organisation.

# Are services well-led?

Requires improvement 

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

## Our findings

### Vision and strategy

The practice had yet to formalise their vision, strategy and practice values. The practice manager described the practice's vision for improving services provided for patients, with particular emphasis placed on training current staff and developing their roles. We spoke with four other members of staff who described the practice's focus on delivering quality care for patients, however they were not aware if the practice had documented visions and values in place. We did not see any information on values displayed within the practice.

### 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. Most policies we looked at had been reviewed and were up to date, with the exception of the safeguarding vulnerable adults policy and the child protection policy which required updated contact details for the local safeguarding teams. Staff were aware of the practice's policies and how to locate them.

The management team consisted of the GP principal, practice manager and nurse. They attended meetings with the Clinical Commissioning Group (CCG), local networking group, and local practice managers, and we saw minutes to confirm attendance at these meetings.

The practice had some systems for identifying, recording and managing risks. Health and safety policies and a business continuity plan were in place, equipment was checked regularly, and an infection control risk audit had been carried out. Improvements were required for fire safety and, health and safety training for staff.

### Leadership, openness and transparency

The practice had identified leads for different areas including chronic disease management, infection control, safeguarding, information governance, and complaints. We spoke with five members of staff and they were all clear about their own roles and responsibilities, and knew who to go to in the practice with any concerns. The management team met informally to discuss how the practice was performing, and weekly staff meetings were held with the administrative team, however the practice did not document minutes for these meetings.

### Practice seeks and acts on feedback from its patients, the public and staff

The practice was seeking feedback from patients via an in-house survey, which was given out to patients. They had yet to analyse the results of the survey as it was still on-going. Staff told us that extra clinical sessions were occasionally offered on Thursday afternoons in response to feedback from patients, but the practice had not documented how this feedback was received or reviewed, or the learning achieved as a result. The practice did not have a patient participation group, and the practice manager told us there were no immediate plans to implement one.

Practice meetings were not formally scheduled and were arranged when senior staff needed to relay information to the team. The practice manager informed us that the management team met regularly with clinical and administrative staff to seek their views, however these discussions were informal and not documented. Staff confirmed they could approach the GP principal and practice manager on a daily basis, and found them to be open and willing to listen to their concerns and feedback. Staff told us they felt valued and supported in their roles.

The practice had a whistleblowing policy which was available to staff electronically on any computer within the practice. All the staff we spoke with were aware of what whistleblowing meant, how to locate the policy, and who to approach should they have any concerns.

### Management lead through learning and improvement

We were told that staff had annual appraisals which identified personal development. We checked four staff records. One member of reception staff told us they had undergone their appraisal this year, however the documentation was not present in the staff member's file. We reviewed another two files for administrative staff and found one contained an appraisal and personal development plan for this year, and the other did not. The nurse was due for appraisal next year.

Staff told us that the practice was very supportive of training to maintain their professional development. An example included the practice supporting a non-clinical member of staff to complete a nursing qualification. Another example was the practice arranged for a receptionist to undergo training as a health care assistant and phlebotomist.

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers</p> <p><b>How the regulation was not being met:</b></p> <p>The registered person did not identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. There were no records to ensure medicines and emergency equipment were monitored for stock control and expiry. Audit cycles were not completed to monitor and improve quality of care. Formal records to monitor and evaluate staff learning were not available for all staff. The practice had not carried out risk assessments for legionella, or recent risk assessments for fire safety. Regulation 10 (1)(a)(b)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records</p> <p><b>How the regulation was not being met:</b></p> <p>The registered person did not ensure that service users' records were kept securely. Regulation 20(2)(a)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p><b>How the regulation was not being met:</b></p> <p>The registered person did not ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated</p>

This section is primarily information for the provider

## Compliance actions

activity. An enhanced criminal record check had not been obtained for the nurse, health care assistant, and a receptionist who carried out chaperone duties. Regulation 21(b) Schedule 3 (2)(b)(3)(a)(b).