Edridge Road Community Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Edridge Road Community Health Centre provides a GP service to 5,400 patients in the Norbury and Upper, South and West Norwood areas of Croydon and a Walk in Service for people in Croydon and those who live outside the area and or unregistered patients.

We carried out an announced comprehensive inspection on 8 October 2014. The inspection took place over one day by a lead inspector and a GP specialist advisor with an observer from the Department of Health.

Overall the practice is rated as good.

Our key findings were as follows:

- We found the practice was caring, patients felt their privacy and dignity were respected, that they received good or appropriate care and treatment, that the doctor or nurse had time to listen to them and explain any treatment, medicines or referrals to them. Patients said the repeat prescription process worked for them.
- We found the practice was safe with suitable systems in place to deal with medical emergencies, to monitor infection control, to protect children and vulnerable adults from harm and to manage medicines.
- We found the practice was effective. Staff were up to date with best practice guidance. There were lead GPs for long term conditions. Systems were in place to work with other health and social care providers.

We saw several areas of outstanding practice including:

- The service provision and shared care arrangements for people with mental health problems. The use and review of care plans to prevent hospital admission the number of regular health checks completed with patients seen at the walk in centre rather than being referred to mental health services.

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

Importantly, the provider must:

- register with CQC to provide the regulated activity family planning.

In addition the provider should:

Summary of findings

- continue work to address the issues with telephone answering and waiting times;
- complete appraisals for all staff;
- provide supervision for all reception staff and
- provide training for new reception staff on dealing with difficult situations.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated good for providing services that are safe.

Systems were in place to report incidents. Significant events were analysed and learning identified was shared amongst all staff. Policies, procedures and practices protected children and vulnerable adults from abuse. Medicines were well managed with suitable arrangements and systems in place for storage, checks on expiry dates and checking the fridge temperature. We found the practice was clean and arrangements for cleaning were effective with regular checks completed. Staff had access to the equipment they needed to carry out their role. Staff recruitment policies were in line with requirements, although while the paper system was being replaced by electronic records it was not always possible to see references for staff. Arrangements were in place for responding to risk and dealing with emergencies.

Are services effective?

Good

The practice is rated good for providing effective services.

Clinical staff kept up to date with best practice guidance and this information was discussed at monthly clinical meetings. The practice followed the CCG protocols for prescribing. There were lead GPs for each long term health condition and the individual gave staff training and support when required. Where data showed improvements were required, the practice was working to improve. For example, increasing the number of women who attended for a smear test. There was a suitable staff skill mix and staff had access to training to carry out their role. Some improvements were required to the supervision and appraisal arrangements for nurses and reception staff. Suitable systems were in place to share information and have meetings with other health and social care services. Staff said they provided opportunistic health and lifestyle advice. All new patients had a health check. Information leaflets were available to help patients maintain a healthy lifestyle.

Are services caring?

Good

The practice is rated good for providing caring services.

Patients said they were treated with kindness and respect and felt their privacy was maintained. We saw staff spoke with patients in appropriate ways. Patients were involved in decisions about their

Summary of findings

care and treatment. The only issues patients raised related to getting through on the telephone to make an appointment and the time they waited when they attended the practice. Ways to improve privacy in the reception waiting area should be explored further.

Are services responsive to people's needs?

Requires improvement

The practice is rated requires improvement for providing responsive services.

Some patients reported difficulties in getting through to the practice on the telephone and waiting when they arrived for their appointment. This was a long standing issue and while the practice had put in systems to improve they had not taken effect at the time of our inspection. However, the population health needs were well known and the practice services were developed to meet them. The building was purpose built and fully accessible for patients with mobility problems. Staff had access to interpreters when required. The practice was open seven days a week from 8am to 8pm and offered a range of bookable and urgent appointments for registered patients and a walk in service for unregistered patients. Suitable arrangements were in place for dealing with repeat prescriptions. The practice manager was responsible for dealing with complaints. Patients were made aware of the complaints procedure. Records showed complaints were responded to and any learning points were shared amongst staff. While the health centre were actively seeking participants to join the Patient Participation Group, this was still in its infancy and meetings had not taken place to discuss improvements for patients.

Are services well-led?

Good

The practice is rated requires improvement for being well-led.

The clinical lead told us their values and vision for the practice. Staff we spoke with held similar values and wanted to provide good quality healthcare to all patients. The provider had core policies and procedures which staff were familiar with. There were lead roles for safeguarding and infection control and staff were clear about who to report issues and concerns to. Staff said it was a supportive and good place to work and they were happy to be working there. Suitable systems were in place to learn from significant events and complaints. There were a variety of regular, minuted meetings, for all staff, to keep them informed of important changes and give staff opportunities to share their ideas and suggestions. Risk assessments were completed and contingency plans were in place should there be a fire or power loss which meant they were not able to provide a service at Edridge Road.

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 and treatment of older people.

The practice had 29 patients over the age of 75, which is lower than the local average. All had a named GP with 23 having been told they had a named GP. Two of the GPs had a special interest in the care of the elderly and had completed additional training to help them meet the specific needs of this patient group. The practice had looked at why they had fewer numbers of older people than other local practices and had put it down to their location, being close to the town centre where there were higher numbers of younger people and possibly due to a lack of parking facilities at the practice. Croydon had a health visiting service for vulnerable, frail and isolated older people which staff at the practice referred patients to when required. There was a lead safeguarding GP and nurse who were available for all staff to discuss issues or concerns. Meeting minutes showed reflective learning sessions were held, an example of this were discussions about how the practice would use new patient referral system for health visitors and age concern. Systems were in place to call older patients to the practice for the flu vaccine each year. The practice achieved 63% of eligible patients receiving the flu vaccine in 2013. They had reviewed why this number was low and concluded it was due to the high transient population. An action plan had been developed, and they were using text messaging to improve coverage for patients. Reception and clinical staff had leaflets and information about council and voluntary services for older people in the local area.

People with long term conditions

Good

The practice is rated as good for the care and treatment of patients with long term conditions.

The practice had a clinical lead for each long term condition. The leads were allocated time each week to keep up to date with changes and developments and attend regular training sessions. Patients with long term conditions were invited for regular reviews of their medication to ensure the treatments remained appropriate. The practice worked with other health and social care services to provide joined up care for patients with complex health needs. The nurses and health care assistant gave patients advice on health promotion including diet and exercise.

Summary of findings

Families, children and young people

Requires improvement

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

A midwife was at the practice every Tuesday to provide antenatal care to both registered and walk in patients. A health visitor held a baby clinic once a week to give parents advice and child immunisations were given in line with national guidelines. The number of childhood immunisations the practice had given was below the average for the Clinical Commissioning Group. The practice worked with Croydon Community Health Services regarding breastfeeding and provided a baby feeding area. The practice had a baby changing room and an area to leave pushchairs. One GP and nurse were safeguarding leads; their role involved being available for staff to discuss concerns or issues as well as providing training sessions. Staff told us they did scenarios and case discussions on a regular basis at staff meetings. One of the doctors provided contraceptive and sexual health advice. The practice offered Chlamydia and Gonorrhoea screening and free condoms were provided for patients under the age of 25.

Working age people (including those recently retired and students)

Good

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

The practice was open from 8am to 8pm seven days a week. They provided a range of pre-booked and emergency appointments and doctors did telephone consultations, providing a flexible service for people who worked office hours or who were in full time education. The nurses and health care assistant provided smoking cessation and healthy eating information and advice. Cholesterol tests were carried out for high risk patients.

People whose circumstances may make them vulnerable

Good

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

People could use the walk in service without being registered at the practice and people who were homeless could see a doctor. Doctors who worked at the walk in centre told us they gave opportunistic health advice when they saw patients. Referrals were made to other health and social care services when required. Reception and clinical staff had a list of local services including food and clothing banks which they gave to patients. We saw examples of responsive care and treatment being provided for people who were homeless and asylum seekers. Staff had access to telephone and on line translation services. A weekly Polish clinic was provided in response

to high numbers of Polish people attending the practice. The practice provided rapid HIV testing for street sex workers and Chlamydia and Gonorrhoea screening and free condoms for patients under the age of 25. The practice provided a violent patient scheme for the CCG in Croydon. This service was provided to patients who had been removed from the patient list of other GP practices in the area due to their behaviour. Patients were invited to an appointment with the clinical lead and practice manager and were given a behaviour agreement which explained the service and expectations for both the patient and the practice. We were told that there were fewer than five patients on this scheme.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care and treatment of people experiencing poor mental health.

One of the doctors was the lead for mental health and provided a clinic once a week for patients and regular training and support for staff at the practice, in the local community and wider for GPs and other health professionals. The practice had regular meetings with other health and social care providers to ensure patients received joined up care and treatment. They developed care plans for all patients on the mental health register, all of which were reviewed last year. Hospital avoidance care plans were developed with patients at highest risk of hospital admission. Eighty three per cent of eligible female patients had attended for a cervical smear in the last five years. All patients taking lithium had their blood levels tested in the last nine months with 50% in the last four months. Ninety six per cent of patients had a record of their alcohol consumption in the last year and records of their body mass index in the last year. The practice provided a shared care arrangement for people with alcohol and drug dependence in conjunction with a local provider. The practice had low referral rates to mental health services because they saw patients at the special clinics and walk in centre, reducing the need for individual patients to use specialist resources. Clinical staff told us they provided opportunistic health promotion for patients using the walk in service. The GP responded to a patient request during the inspection, going above and beyond what was expected.

Summary of findings

What people who use the service say

We spoke with four patients during our visit and received 19 comment cards, completed by patients who visited the practice during the two weeks before the inspection.

Comment cards indicated patients using both the walk in centre and the GP practice were happy with the service they received. Patients we spoke made positive comments about the practice opening hours and it being open every day. Eighteen of the nineteen comments cards received were positive. Comments about staff were positive, reception staff were described as helpful and we were told doctors and nurses were understanding, supportive and respectful. Patients felt their privacy and dignity was respected and that staff spoke with them appropriately. Patients confirmed that the repeat prescription service worked for them and when they had been referred to other services this had been well managed.

Patients told us the practice was usually clean. Patients were aware of how to make a complaint and three had not needed to. One patient had made a complaint and stated they had not received a satisfactory response, although this had been some time ago.

The area patients raised concerns about were the difficulty in making an appointment, actually getting through on the telephone and then when they arrived for their appointment waiting, or if they were a walk in patient waiting to be seen and not really knowing how long they were going to have to wait. One patient told us that while they had to wait to see the doctor, they knew the doctor would give them the time they needed.

The results from the 2014 GP survey showed 93% of patients were happy with the opening hours. Seventy % rated the practice as good or very good, 63.9% said they would recommend their GP. Only 56% were satisfied with the arrangements for making an appointment and 35% rated their ability to get through on the telephone as acceptable, these were amongst the lowest figures in the CCG area.

Areas for improvement

Action the service MUST take to improve

- register with CQC to provide the regulated activity family planning

Action the service SHOULD take to improve

- continue work to address the issues with telephone answering and waiting times;
- complete appraisals for all staff;
- provide supervision for all reception staff and
- provide training for new reception staff on dealing with difficult situations.

Edridge Road Community Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Lead inspector with a GP specialist advisor who were accompanied by an observer from the Department of Health.

Background to Edridge Road Community Health Centre

Edridge Road Community Health Centre is a GP led health centre with 5,400 patients on their list and they operate a walk in service for patients who are not registered. The practice is open from 8am to 8pm seven days a week. It is in the heart of Croydon and has a diverse population, although below the Croydon average number of older people. There are five GP's, (three are female) and 14 locum GPs, (six of whom are female) and six nurses and one female health care assistant working at the practice.

The practice is registered with the Care Quality Commission to provide the regulated activities of: diagnostics and screening, maternity and midwifery, treatment of disease, disorder or injury and surgical procedures at one location. They were not carrying out surgical procedures at the time of our visit so we did not look at this regulated activity.

The practice has an Alternative Provider Medical Services contract and provides a full range of essential, additional and enhanced services including maternity services, vaccinations and immunisations, baby clinic, cervical smears and sexual health information and advice and family planning services.

The practice had an inspection in December 2013, all areas inspected were found to be compliant, and the only issues raised were regarding the time some patients had to wait to see a GP when they attended the walk in centre and patients confusion about where to wait for the different services.

Edridge Road Community Health Centre is one of 18 practices operated by The Practice Surgeries Limited.

The practice has opted out of providing out-of-hours services to their own patients, out of hours patients were advised to ring the NHS 111 service.

Why we carried out this inspection

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.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, including the Clinical Commissioning Group, NHS England and Healthwatch Croydon to share what they knew. This did not highlight any significant areas of risk.

We carried out an announced inspection visit on 8 October 2014. During our visit we spoke with a range of staff including two salaried GPs, one locum GP, two nurses, the healthcare assistant, three reception staff and the provider's business manager who was covering for the practice manager. We spoke with four patients who used the service. We observed how people were being cared for and talked with carers. We looked at records including clinical audits, significant events, staff recruitment and training files, health and safety checks and equipment maintenance, complaints and the provider's policies. We looked at how records, medicines and equipment were stored. We reviewed comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

Suitable arrangements were in place for recording and reporting incidents, including notifying the Care Quality Commission. One of the doctors was the lead for staff to report incidents to. Staff we spoke with were aware of incidents and issues that required recording and reporting and were clear about their role and would report issues to the doctor or other staff in their absence. Reports were recorded electronically and were automatically sent to the line manager of the person completing it and the provider's governance department, which was based at the provider's head office. There was a risk scoring system which meant issues with a higher risk were sent to more senior people in the organisation for action and information. Forms with a score above six went to the business manager who reviewed them and ensured any actions needed were completed promptly. We saw an incident report completed by staff which stated there had not been basic life support training; this was flagged to the governance department. Staff training records showed this training was provided the following month.

The provider had developed policies and procedures for safeguarding, infection control and health and safety. These documents were kept under review and accessible to staff.

Systems were in place for the clinical lead to receive national safety alerts, including those from the Medical and Healthcare Products Regulatory Authority and cascade this information to other staff. Records showed these alerts were shared with staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Records indicated incidents were discussed amongst staff with changes made to prevent recurrence. Staff meeting minutes showed incidents were discussed to ensure all staff were made aware. Significant events analysis showed staff reviewed their actions and processes when a patient collapsed in the waiting room. Meeting minutes showed staff went through significant events and any learning identified was shared. An example of this was the discussion after a medical emergency; staff reviewed their actions and looked at whether they could have done anything differently.

There were panic alarms in clinical rooms which were checked weekly and staff spoken with were aware of the actions they needed to take if an alarm sounded.

Reliable safety systems and processes including safeguarding

The provider had child protection policies and procedures and a copy of the pan London child protection procedures were available to staff. One of the doctors and a nurse were the safeguarding leads to whom staff reported concerns or issues to be referred to the local authority. The GP had regular contact with the multi-agency safeguarding hub (MASH). Clinical staff spoken with had completed child protection training to Level 3 and administrative staff to Level 1. Staff spoken with were clear about what constituted abuse and the actions they needed to take to protect children. Staff gave examples of concerns that had been referred to children's social services and staff meeting minutes showed they used examples for reflective practice. There was a system on the electronic records to identify if a child was subject to a child protection plan which ensured staff were aware when there were concerns.

Suitable policies were in place for the protection of vulnerable adults. The practice induction included training on safeguarding and records identified some staff had completed additional training on safeguarding vulnerable adults. Staff were completing a safeguarding audit of records to ensure clinical staff were recording the required information in consultation notes. Monthly meetings included a safeguarding section. We saw a safeguarding trigger prompt notice in each consulting room, this reminded staff of the areas to consider and record in patient notes.

The practice had a chaperone policy; this stated that a nurse would attend an appointment with a patient if requested. Nurses we spoke with were clear about their role when they acted as chaperone.

Medicines management

Medicines were securely stored with suitable systems in place for checking medicines; those we looked at were in date. The temperature of the fridge where immunisations were stored was checked and recorded daily. Staff we spoke with were aware of the correct range and were aware of the actions they needed to take if the temperature went outside of this. Prescriptions were stored securely. There were no controlled drugs stored at the practice.

Good

Are services safe?

The protocol for repeat prescribing was in line with local and national guidance. There was clear guidance for staff when they reviewed patients' medicines and wrote repeat prescriptions. Systems were in place to ensure annual medicines reviews took place for patients with long term conditions. This was recorded on the electronic patient record which had a 'flag' to show when the review was required.

Clinical staff who gave injections had received suitable training. Staff told us they record the vaccination batch numbers in the individual patient record.

Cleanliness and infection control

Policies and procedures for infection control were available to staff. Staff completed training in infection control as part of their induction to the practice. One of the nurses was the infection control lead and carried out regular audits including hand washing. Records showed no issues at the last audit. All equipment used was single use so the practice did not have a steriliser.

There was a cleaning schedule and external contractors attended the practice twice each day. They cleaned the whole building in the morning and revisited the heavily used areas in the afternoon. Monthly audits of the cleaning were carried out and records showed they had achieved between 94% and 97% in these audits in the past year. There were systems to report issues with the cleaning. Patients told us the practice was usually clean.

Reception staff had access to personal protective equipment and spill packs should there be a spillage of bodily fluids in the reception and waiting area.

Clinical and domestic waste was stored separately throughout the practice and contracts were in place for the removal of clinical waste.

There was regular testing of the water for Legionella and the system was flushed twice each week. (Legionella is a germ which can contaminate water systems in buildings).

Equipment

Doctors and nurses had access to equipment they needed to carry out their role. Systems were in place for medical equipment to be checked, tested or calibrated every year. This was last carried out in May 2014.

A fire risk assessment was completed in May 2014; we were told that issues raised were to be addressed by NHS England. Suitable arrangements were in place for the fire alarm to be tested weekly and serviced annually. Fire extinguishers were checked in June 2014. Portable electrical appliances were checked in May 2014.

Staffing and recruitment

The provider had suitable recruitment policies which included the required checks being made before staff started work. Staff files seen were a mix of paper and electronic records and we were told these were being moved to be electronic only. We looked at records for six members of staff and in four of these there were no references. Whilst there were records of Disclosure and Barring Service checks having been completed for all six staff, there was no system to update these when they expired. When doctors or nurses were employed, checks were made of their qualification and registration with either the General Medical Council or Nursing and Midwifery Council. Evidence of checks on the person's identity were in place. Records showed the hepatitis status of clinical staff was checked when they started work.

The practice told us that they used their own bank of locum GPs and had not needed to use a locum doctors from an agency for 4 years.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual risk assessments and regular checks of the environment and equipment, infection control and medicines management. The practice had suitable health and safety policies and relevant information was displayed for staff. A recent assessment identified that blinds were needed in the reception area. We were told that they were getting quotes and would be addressing this in the future.

Case discussions were held at clinical meetings, where doctors brought information about patients with long term health conditions or complex care and treatment needs for information and advice. These meetings were also used to update all staff on changes in treatment and care plans for individual patients. Repeat prescribing for patients with mental health problems were kept under review. The clinical lead described how they used daily prescriptions for high risk patients.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

Suitable arrangements were in place to manage emergencies. Records showed that all staff received annual training in basic life support. Emergency equipment was available including oxygen with equipment separated for adults and children and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff we spoke with were clear about where emergency equipment was located. Records showed emergency equipment was checked daily.

Emergency medicines were easily accessible although securely stored and staff knew where these were. Processes were in place to check 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 and reviewed annually. There was a paper document that staff could take with them if they needed to leave the building for any reason and this was also available electronically. There were clear actions for staff to take in the event of a range of emergency situations including a power cut, flood and adverse weather. Emergency contact details for repair services were readily available to staff. Records showed fire drills were held regularly and a fire risk assessment had been completed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were clear about their approaches to treatment. They kept up to date with the current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and the Clinical Commissioning Group (CCG). One doctor told us the CCG prescribing protocols were accessible to them on the electronic recording system.

One doctor told us that while they used guidelines, for some patients they put the individual's needs first. For example the use of antipsychotic medicines for patients using the walk in centre who may not be registered with a GP and may not be getting the appropriate medical treatment for their condition. The practice had a mental health lead who was involved and kept up to date with the latest guidance regarding mental health treatments and worked closely with the community mental health team.

The practice used data from the CCG to benchmark areas including accident and emergency attendance, prescribing and referrals. Records showed they were low on the referral rates to mental health services and high on prescribing mental health medicines, although this was put down to the lead for mental health providing services to patients at the practice rather than referring patients to other services.

There were lead GPs for long term conditions including asthma, chronic obstructive pulmonary disease, coronary heart disease, dementia, diabetes, depression, epilepsy, hypertension, kidney failure, learning disability, palliative care and stroke. Staff in this role were given time to keep up to date with guidance including attending relevant training and providing training and support to colleagues.

Doctors told us that they made referrals and provided treatment depending upon patient need. Doctors were only able to make emergency referrals for patients using the walk in centre. For non-urgent referrals patients were told to go to their own GP or invited to register with the practice to be referred.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs identified that the culture in the practice was that patients were referred on the basis of need and that age, gender and race were not taken into account during the decision-making.

Management, monitoring and improving outcomes for people

The practice was clear about where they stood in relation to the Quality and Outcomes Framework (QOF), the voluntary incentive scheme used to encourage high quality care, with indicators used to measure how well practices were caring for patients. Records showed the practice were in line with the CCG average. Information from the practice was reviewed by the CCG and this was shared amongst staff at meetings. The practice had systems in place for completing clinical audit cycles and the findings were shared amongst staff.

An audit of controlled drugs in 2012 identified that no changes were required. This was not repeated because they no longer kept controlled drugs.

There were no patients receiving end of life care at the time of our inspection. One of the doctors was the lead for end of life care and had links with the local hospice. The practice held quarterly meetings regarding palliative care and systems were in place for referral when a patient needed this service.

The doctors told us that patients who attended the walk in centre who were not registered with a GP were invited to register at the practice.

The practice were working to improve the number of women who attended for smear tests. Sixty per cent of eligible patients attended in the year to October 2013 and 58.4% in the year to October 2014. The health care assistant contacted women who were overdue for a test to invite them for an appointment and talk to them about the process and why it was important for their long term good health.

The practice participated in the local initiative to 'celebrate and protect'. This involved sending immunisation birthday cards to parents to remind them of the immunisations their child needed. The practice figures for childhood immunisations were 75% for the 5 in 1 vaccine for babies to protect them against diphtheria, tetanus, whooping cough polio and Hib (Haemophilus influenzae type b). Figures for the pre-school booster showed the practice had immunised 66% of eligible children, protecting them against diphtheria, tetanus, whooping cough and polio. (The CCG average was reported as 74.6%). These figures were below the average for the CCG area.

Good

Are services effective?

(for example, treatment is effective)

We were told that care plans were developed for 'hospital avoidance' with some patients to support individuals in managing their symptoms out of hours.

Effective staffing

Staff told us there were sufficient doctors, nurses, healthcare assistants, administrative and managerial staff to provide the services. After a review of clinical staff, an additional doctor worked on a Monday and extra nursing staff worked Saturday afternoons, these had been found to be 'busy' times at the practice. We saw clinical staff had the required skill mix to meet the needs of patients who used the service.

We looked at staff training records, which were a mix of electronic and paper records. We saw staff had completed mandatory training and updates, usually in the required time frame. However it was not easy to check that all staff were up to date. Reception staff had not completed training in dealing with difficult situations which they may find useful. The practice had developed an induction programme for new staff. This included the clinical lead completing the induction checklist with the individual and each lead spending time with new staff to go through their areas of responsibility.

Nurses said they were adequately staffed and used locum or agency nurses when required. The nurses and health care assistant said they felt supported by the GPs and that their training and development needs were met. The nurses had completed training to enable them to carry out their role regarding health promotion, including smoking cessation, diabetes and family planning. Two staff we spoke with had not had an annual appraisal, we were told this was because the practice manager was off work and would be arranged by the provider's lead nurse.

Arrangements for the supervision and appraisal of reception and administrative staff were not in place while the practice manager was off work. The business manager told us they would be responsible for this in the interim and confirmed these had taken place by email after our inspection.

GPs we spoke with had annual appraisals and two had been revalidated In September 2014, the other doctors were working towards theirs. (Revalidation is the process by which doctors demonstrate they are up to date and fit to practice).

Working with colleagues and other services

Suitable systems were in place for managing blood results, x-rays and discharge letters. These were checked each morning by the duty GP and any actions arising were allocated to a GP. Patients we spoke with were satisfied with the arrangements for referrals to other health services.

Monthly meetings were held with other health professionals including district nurses, community matron, health visitor and social services to ensure patients received joined up care and treatment and were referred on to other services when required.

The practice held regular GP meetings each month, one included a teaching session and one was a clinical meeting. The clinical lead attended monthly meetings with the CCG and reported back to other staff.

Information sharing

The practice had a system for the records of patients seen at the walk in centre to be sent to the patients GP the next morning.

Systems were in place for the out-of-hours service to send records of patients seen, these were checked by doctors each day to ensure any actions were completed. While they were not needed at the time of our inspection, the practice used special patient notes for patients receiving end of life care, to ensure all doctors and the out of hours service had the most up to date information to provide appropriate care and treatment.

Consent to care and treatment

Clinical staff were aware of their responsibility to seek consent before providing treatment or carrying out an examination. They had not completed formal training on the Mental Capacity Act but were clear about their responsibilities. They were aware of when best interest decisions would be needed and how to ensure children were legally able to consent to treatment by demonstrating an understanding of Gillick competence. There was a clinical lead for dementia, learning disability and mental health who was able to give staff support if they needed regarding gaining consent or acting in a patients best interest. The practice was not carrying out minor surgery at the time of our inspection so there were no written consents to view.

Health promotion and prevention

New patients completed a questionnaire of basic information including their family health concerns, their

Good

Are services effective?

(for example, treatment is effective)

smoking status, the amount of alcohol they consumed and whether they were a carer. The health care assistant saw all new patients and used the questionnaire to give the individual specific health and lifestyle information and refer them to the diabetic nurse or doctor and to the local diet and exercise services if required and direct them to relevant support services.

Staff we spoke with all said they would give opportunistic health advice and information to patients, especially those using the walk in service who may not have seen a GP for years.

Staff said they would offer the flu vaccination to eligible patients when they attended the practice.

The electronic recording system identified patients who needed additional support, including those with a learning disability; those receiving end of life care and patients with diabetes and other long term health conditions. All patients on the learning disability register had received an annual health check. There were systems to check that routine health checks were completed for patients with long-term conditions including diabetes. All patients with diabetes had had a dietary review in the last year, 95% had their blood pressure tested. Ninety three per cent of patients newly diagnosed with diabetes had been referred to an education programme. The practice identified that 64% of patients with diabetes had retinal screening. The health care assistant and diabetes nurse were working through patient records to prompt patients to attend.

The nurses and health care assistant were trained in smoking cessation and were able to refer walk in patients to smoking cessation clinics at the practice.

We saw a range of leaflets and posters in the waiting area advising patients about how to maintain a healthy lifestyle and informing them of the various clinics and services available at the practice. Patients said the doctor or nurse spoke with them about their lifestyle and about how to improve their health if appropriate.

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 2014 national patient survey and comments on NHS Choices website. These sources of information gave mixed feedback. According to the national survey 93% of patients who responded said the last GP they saw was good at treating them with concern which was amongst the highest in the CCG area with the average being 75%. Sixty four per cent of patients who responded would recommend their GP practice to others and 71% of patients rated the practice as good or very good, both of which were among the worst in the CCG area.

We received 19 patient comment cards from patients who visited the practice during the two weeks before our visit. Eighteen of these cards contained positive comments about the staff and the level of care they received. Patients we spoke with said they were happy with the clinical support they received and felt their privacy and dignity were respected when they visited the practice. Patients described the doctors as understanding, responsive, helpful and empathetic.

The provider had policies for staff regarding respecting patients privacy and dignity. Staff told us that consultations took place in rooms with the door closed. Curtains were provided in consultation rooms to provide privacy during examinations.

The reception area was open and during our visit we saw patients queuing close together so conversations could be overheard. There was an electronic check-in system, although it was not clearly visible or easily accessible to patients when they first walked into the practice. The provider was exploring ways to improve patient privacy at the reception desk.

Staff told us they welcomed all patients and people at the practice, regardless of their circumstances and access to a GP was not dependent upon the individual being registered at the practice. We saw reception staff and doctors spoke to patients in appropriate ways during our visit.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said the doctors and nurses listened to what they said, they were involved in making decisions about the care and treatment they received and the doctor or nurse took time to explain things to them in ways they understood. This was in contrast to the results of the national patient survey. Some patients said that while the appointment times were meant to be kept to ten minutes, this did not always happen and they were satisfied that this meant they would get the time they needed with the doctor, even if they had to wait.

Eighty two per cent of respondents in the national patient survey 2014 said the doctor involved them in their care and treatment.

Staff told us they had access to face to face and telephone interpreting services when required and patients were informed of the availability of this service.

There were a range of information leaflets about different long term health conditions and how to develop and maintain a healthy lifestyle in the waiting area for patients. Clinical staff told us they provided opportunistic health advice to patients who attended the walk in centre and attended the GP for booked appointments.

A clinic for Polish speaking patients was held every week enabling patients to have a consultation with a doctor in Polish. This clinic had been developed to meet the needs of local patients.

Patient/carer support to cope emotionally with care and treatment

Reception and clinical staff had information about local services and support groups to refer patients to when required.

Clinical staff we spoke with said they would work with patients and their relatives and carers to ensure individuals received their preferred care and treatment as they approached the end of their life. We found the practice did not have a policy regarding bereavement which may be useful for staff.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the local population were well known and understood and the practice was responsive to those needs. We saw that the services provided were flexible to meet patient's needs. Some examples of this were the provision of a clinic for Polish speaking patients, the shared care arrangements for people with mental health problems with a local drug and alcohol centre and the midwife led antenatal clinic for walk in and registered patients.

Reception staff had a list of minor illnesses and were trained to advise patients where it was felt appropriate to attend the in-house pharmacy for advice from the pharmacist.

We saw the practice was baby and child friendly with the provision of a breast feeding room, baby changing area, indoor storage for pushchairs and a play room.

Staff spoken with were aware of local services including food and clothing banks and the support groups and services available and would direct both walk in and registered patients to relevant services.

Doctors said they asked walk in patients if they were registered with a GP and if they had seen them about their current health concern. They invited unregistered patients to register with them. They did not audit the number of walk in patients who then registered with the practice.

There was always one GP for registered patients and one GP for walk in patients. Following reviews of staff levels and demand, a third GP worked on Mondays and additional nurses worked on Saturday afternoon.

One of the doctors attended regular meetings with the Clinical Commissioning Group (CCG), who, along with other practices looked at the improvements needed to meet local health needs. One area the CCG was working on was improving diabetes management and care. The practice had a clinical lead for diabetes and a specialist diabetes nurse. They offered a range of appointments and clinics for patients. Clinical staff attended regular training updates to ensure they used the most up to date guidance.

We saw information inviting patients to join the Patient Participation Group (PPG). Patients we spoke with had not attended any meetings. While there had been some thinking about a PPG this was still in early development and meetings had not been held.

Tackling inequity and promoting equality

Staff told us they could access face to face and telephone interpreters when needed and said staff at the practice spoke a number of languages so they could be called upon if required.

The practice provided health care services to everyone who attended. We were told they saw homeless people and asylum seekers. The practice provided a violent behaviour service for patients in Croydon who had been asked to leave another practice list. Patients were asked to sign a behaviour agreement which explained the service and expectations for both the patient and the practice.

The electronic recording system had an indicator system to show if a patient was vulnerable, if they were a child 'looked after' by the local authority and if a child was on a child protection plan.

Access to the service

The practice was open seven days a week from 8am to 8pm and offered a range of bookable and walk in appointments for registered and unregistered patients. For registered patients, the next bookable appointment on the day we visited was three days later. The last available appointment each day was 7.50pm. Registered patients could make urgent, on the day appointments or have a doctor ring them back to discuss their concern. Doctors carried out home visits when they felt it was necessary. Notices on consultation room doors stated appointment times were ten minutes, although doctors and patients said this was not always the case. Longer appointments could be booked and reception staff were clear about the services that required a longer appointment time.

Patients made positive comments about the practice opening times which were convenient and gave them daily access to a doctor or nurse from early in the morning to the early evening.

The concerns patients raised with us included the difficulty they experienced getting through to the practice on the telephone. This was supported by the findings of the 2014 national patient survey where only 35.4% of patients rated their ability to get through on the phone as good and 55.9%

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

of patients rated their experience of making an appointment as good which were some of the lowest results nationally. The practice had a patient rating of 1.5 stars out of a possible 5 based from 77 patient comments posted on the NHS Choices website in the last year. We saw the comments raising concerns were around answering the telephones and patients experience when attending appointments. The practice manager had responded to a few comments but the majority were left unanswered. The issue with the telephones had been an issue in February 2013 when the practice had tried to improve the situation, although further improvements were still required.

Another issue patients raised with us was the time they waited when they attended the practice for an appointment. We discussed this with the lead doctor and business manager who said they had tried various things to improve the patient experience when they attended the practice. One initiative was the addition of an electronic check in system, although this was not easily accessible to patients during our visit. They had tried to use a ticket system, patients took a ticket on arrival and waited to be called to the reception desk, although feedback to this had not been fully analysed.

The practice was in a purpose built health centre, they shared the reception and waiting area with the contraceptive and sexual health service. There was an on-site pharmacist, an emergency dental service and a breast screening service in the building which were managed by other providers. The reception and waiting area and all consultation rooms were on the ground floor. The practice was accessible for people with mobility problems and those who used a wheelchair.

There was a security guard for the building who was based in the reception area, reception staff said they valued this. We saw the person supporting patients when they arrived, directing them where to go.

Listening and learning from concerns and complaints

There was a suitable system for handling complaints and concerns. The practice complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for dealing with complaints in the practice. Staff we spoke with were clear about their responsibilities regarding dealing with complaints and concerns.

We saw records of complaints received in the last year and the actions taken. Four complaints related to the time it took patients to make an appointment and the length of time they waited when they attended for an appointment. Two of the four patients we spoke with said it could be difficult getting through to make an appointment.

Staff meeting minutes showed complaints were discussed at meetings, although the four we saw discussed at a meeting in September were not the ones we saw on the electronic records.

Information about how to make a complaint was made available to patients. Patients we spoke with were aware of how to make a complaint. One patient had made a complaint and stated they had not received a satisfactory response although this had been some time ago.

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 statement of purpose. The clinical lead had a clear vision about the services they were providing and aspirations for the future of the practice, although these were not all recorded. All staff we spoke with wanted to provide high quality health care and promote healthy lifestyles to everyone who attended the practice and clearly had the same ethos as the clinical lead.

Governance arrangements

There were safeguarding and infection control leads, staff in these roles understood their responsibility and all staff knew who to report concerns and issues to. All staff had job descriptions.

The provider had developed suitable policies and procedures that were accessible to all staff and kept under review. Staff spoken with demonstrated an understanding of the core policies regarding infection control, safeguarding and health and safety and their responsibilities.

The practice was operated by a provider who had 18 similar services. There was a clinical lead at the practice who made decisions with the practice manager that were approved by the provider. The provider had a clinical lead and director with a chair person, chief executive and operations director who were responsible for decision making across the organisation.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance and worked with the CCG to see how it compared to local practices. The QOF data showed the practice was performing in line with local and national standards. Meeting minutes showed that QOF data was a regular agenda item and areas for improvement were addressed.

Leadership, openness and transparency

There was a clinical lead who was responsible for decision making with the practice manager. Clinical and staff meetings were held regularly and the minutes were made available to all staff and regular locum GPs. Staff told us they worked well together and felt Edridge Road Community Health Centre was a supportive environment to work in. Staff valued sharing the building with other services and said it supported the provision of joined up care and treatment. The clinical lead was clear that they operated an open and blame free culture.

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

The clinical lead met with the CCG and shared information with all staff. Staff meetings were held and staff were encouraged to bring new ideas and raise issues.

They did not have an active Patient Participation Group (PPG). They did show they listened to patient's comments and complaints. Feedback from patients was discussed at monthly meetings. An example of actions taken in response to patient feedback was the provision of the electronic arrival screen for them to check in.

Management lead through learning and improvement

There is a focus on continuous learning and improvement across the organisation. Arrangements were in place for all staff to learn from incidents, significant events and complaints. Staff spoken with were aware of the learning and improvements from recent significant events and complaints. Clinical staff had monthly clinical and separate teaching meetings, minutes were kept and these were shared with all clinical staff.

The provider produced a newsletter for staff each week; this gave them important updates from the organisation and useful information.

Arrangements were in place for managing risks. Risk assessments were completed, regular checks were made on the building and there was a business continuity plan which contained information for staff to follow in the event of certain situations including fire, flood and loss of power at the practice.