Fryent Medical Centre

Quality Report

331 Church Lane,
London,
NW9 8JD
Tel: 020 8204 6464
Website: www.fryentmedicalcentre.nhs.uk/

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Fryent Medical Centre provides primary medical services to around 2,100 patients in the Kingsbury area of Brent in North West London. It is run by Willow Tree Family Doctors which also operates a larger practice nearby.

We visited the practice on 23 October 2014 and carried out a comprehensive inspection of the services provided.

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

We found the practice requires Improvement for providing safe services.

Our key findings were as follows:

- The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice understood the needs of its patients and was responsive to these. It recognised the needs of different groups in the planning of its services.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

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

Summary of findings

Importantly, the provider must:

- Arrange a programme of regular infection control audit of the practice, and ensure all staff have received up to date infection control training in line with national guidance. In addition, the practice should carry out and document an assessment of the risk of Legionella in line with national guidance.
- Complete a health and safety and fire risk assessment of the building and environment to help ensure patients, staff and visitors are sufficiently protected from the risks associated with unsafe or unsuitable premises.

In addition the provider should:

- Arrange for all staff to complete formal training in safeguarding of vulnerable adults.
- Complete a documented risk assessment stating the rationale for the decision not to carry out a criminal records check for non-clinical staff.
- Communicate the practice's chaperone policy more clearly to patients.
- Arrange for non-clinical staff who occasionally act as chaperones to undergo a criminal records check.
- Ensure the monthly check of medicine expiry dates is recorded.
- Ensure regular checks carried out on medical emergencies equipment are recorded. In addition, staff trained to deal with medical emergencies should receive update training to fully meet UK Resuscitation Council guidelines.
- Record weekly fire alarm system checks and implement a planned schedule of fire evacuation drills.
- Ensure following clinical audits the practice reviews whether care has improved by repeating clinical audits and thereby completing the full audit cycle.
- Document regular clinical governance meetings and administrative staff meetings to help track agreed actions and review progress at subsequent meetings. Record in the minutes evidence of the communication throughout the year of lessons learned from complaints.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Risks to patients were assessed but systems and processes to address these risks were not always implemented well enough to ensure patient safety.

The practice had a policy for the safeguarding of vulnerable adults and staff we spoke with knew how to recognise signs of abuse and the process to follow and who to contact if they suspected abuse. However, the majority of staff had not completed formal training in safeguarding of vulnerable adults. A chaperone policy was in place and staff we spoke with understood their responsibilities when acting as chaperones. However, non-clinical staff who occasionally acted as chaperones had not undergone a criminal records check.

Medicines stock records were maintained and medicine expiry dates monitored. Expiry dates were checked monthly, although the check was not recorded.

There was an infection control policy in place and we observed the premises to be clean and tidy. However, there had not been a recent infection control audit of the practice and we did not see evidence that all staff had received up to date infection control training in line with national guidance. In addition, the practice had not carried out and documented an assessment of the risk of Legionella in line with national guidance.

Appropriate pre-employment checks had been carried out on staff before they started working. We were told that the practice had not carried out Disclosure and Barring Service checks for non-clinical staff on the basis that they did not have unsupervised contact with patients. However, a documented risk assessment had not been undertaken stating the rationale for this decision.

The practice had a health and safety policy and carried out visual inspections of the premises and equipment on a daily basis. However, the practice had not conducted a recent health and safety risk assessment of the building and environment.

Appropriate equipment was available for medical emergencies and we saw it was operational. Regular checks were carried out on the equipment but the checks were not recorded. In addition, some staff trained to deal with medical emergencies required update training to meet UK Resuscitation Council guidelines.

Summary of findings

The practice had a fire policy in place. However, the practice had not carried out a recent fire risk assessment of the premises. We were told staff tested the fire alarm system weekly but this was not recorded. There was no planned schedule of fire evacuation drills and none had taken place recently.

Are services effective?

Good

The practice is rated as good for effective. The practice had scored positively in their QOF performance and used QOF to steer practice activity.The practice participated in clinical audit and routinely collected information about patient care and outcomes. However, we did not see evidence of how the action from audits had been monitored and reviewed by further audit to test its effectiveness and complete the full clinical audit cycle. There were effective arrangements in place to support staff appraisal, learning and professional development. The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment. The practice promoted good health and prevention and provided patients with suitable advice and guidance. The practice offered a full range of immunisations for children.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the National GP Patient Survey showed the practice was rated 'among the best' for patients who said they had confidence and trust in their GP. In addition, the practice scored above the CCG average for patient satisfaction with privacy when speaking with staff. The practice received more mixed ratings for satisfaction scores on consultations with doctors and nurses and some scores were below the CCG average particularly around patient involvement with decisions. However, feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect. We observed this during the inspection and saw that confidentiality was maintained. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the needs of its patients and was responsive to these. Data from the National GP Patient Survey showed the practice was rated above average for being able to get an appointment but below average for convenience and the experience

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of making an appointment. The views from patients we spoke with and who completed comment cards were mostly positive about access to the service. However, there were some negative comments about the difficulty in getting an appointment and getting through to the surgery on the telephone during busy times. The practice had taken a number of steps to improve accessibility in the light of feedback. It was not always possible for the practice to achieve continuity of care but the practice had taken action to improve this. There was an accessible complaints system. All staff attended an annual complaints review meeting where learning points were identified and discussed. Lessons learned were also communicated throughout the year at staff meetings when individual complaints were concluded although these meetings were not documented. The premises and services had been adapted to meet the needs of people with disabilities.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service working in partnership with them. The practice aims were set out in the practice statement of purpose. Although not all staff were aware of the statement, they were able to articulate the essence of these aims and it was clear that patients were at the heart of the service they provided. There was a clear leadership structure with named members of staff in lead roles. Staff were clear about their own roles and responsibilities. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice had a number of policies and procedures to govern activity and these were regularly reviewed and updated. The practice held weekly clinical governance meetings and administrative staff met weekly or fortnightly to be briefed on operational issues and developments, and monthly to receive training and instruction on working practices. Staff had received induction training and regular performance reviews. The practice proactively sought feedback from staff and patients, including a patient participation group (PPG) which it acted on.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. There were effective risk assessment processes in place to identify patients over age 75 at risk of hospital admission. The practice had established a case management register and care plans for at risk patients. Patients on the register were allocated a named GP and care co-ordinator. Home visits were carried out for older patients who were not well enough to attend the surgery. The practice worked closely with district nurses to support the care and treatment of elderly, housebound patients. There were also arrangements in place for engagement with other health and social care providers. Patients at risk of dementia were referred to a memory clinic, followed up by a 6 month follow-up assessment for patients with a confirmed dementia diagnosis on discharge from the clinic. There were appropriate and effective end of life care arrangements in place.

People with long term conditions

Good

The practice is rated good for the care of people with long term conditions. The practice provided services for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance Care plans had been put in place for patients at risk of hospital admission and bypass telephone numbers allocated to enable them to receive same-day telephone consultations or follow-up arrangements when required. The practice held regular meetings with district nurses, care-coordinators, palliative care and health visitors to help establish best care for patients with long term conditions. Increased patient autonomy and self-care was encouraged by providing patients with information on self-care, and sign-posting to self-help groups. The practice was involved in the North West London 'Whole Systems Integrated Care' programme to ensure better co-ordinated care for patients with complex conditions. Flu and pneumococcal vaccinations were offered to patients in at risk groups, including patients with long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided contraception and sexual health services including contraception advice and emergency contraception, smear testing and chlamydia screening. The

practice's performance for cervical screening uptake was 83% in 2012/13 which was better than the average for the CCG area. The practice offered a full range of immunisations for children. Flu vaccination was offered to pregnant women. Most child health checks were provided by health visitors at the clinic immediately next door to the practice with whom the GPs and practice nurse worked closely. Easy access was available for parents/children and patients could phone the practice for advice and be provided with same day appointments. There were procedures in place to safeguard children and young people from abuse. All clinical and all but one non-clinical member of staff had received child protection training in line with national guidance. The practice was also part of the Brent multi-agency safeguarding hub (MASH). This provided a secure email address for sending safeguarding information to social services and enabled the practice to highlight any concerns about family members.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).The practice was accessible to working people. For example, the practice operated extended hours on Monday and Friday. In addition, the practice offered telephone consultations and online booking for this group. The practice offered a full range of health promotion and screening which reflected the needs for this age group. All patients in the 45-74 age group were offered a health check. All newly registering patients were invited to a new registration consultation with the practice nurse to help identify and plan their medical needs. The practice provided 'well person' checks, carried out by appointment with the practice nurse. Health and exercise advice was given at routine appointments. For patients approaching retirement the practice discussed opportunistically their plans and encouraged them to adopt a structured life-style, exercise, good diet and identified the potential risk of depression and relationship stresses due to their changing role. Flu vaccination was offered to patients over the age of 65.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had an open policy regarding registrations. For example, there were two homeless persons on the practice's register and travellers from a visiting fun fair had been temporarily registered. Quick access appointments were available for vulnerable patients, for example if they turned up without a booked appointment. Patients with learning disabilities were reviewed annually and received a physical

Summary of findings

health check, medicines review and blood and other screening tests. The practice had access to an interpreter service and could book a trained interpreter on behalf of patients or they could phone for assistance themselves. The premises and services had been adapted to the needs of patients with a disability. The practice had a policy for the safeguarding of vulnerable adults and staff we spoke knew how to recognise signs of abuse and the process to follow and who to contact if they suspected abuse However, the majority of staff had not completed formal training in safeguarding of vulnerable adults.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice facilitated patients' access to the local 'Improving Access to Psychological Therapies' (IAPT) programme which provided self-help courses for patients with common mental health difficulties such as stress, worry and low esteem. An IAPT counsellor was available on site to provide counselling and psychology services and patients were referred by their GP or could ask for a referral. The practice participated in a CCG commissioned direct enhanced service (DES) to profile patients who may be at risk of dementia. Patients identified as at risk were referred to a memory clinic and follow up assessments were carried out on their discharge from the memory clinic. Regular reviews and medication management plans and recall protocols were in place for patients on high risk medicines, including medicines for patients with mental health conditions.

Summary of findings

What people who use the service say

We received 32 completed Care Quality Commission (CQC) comments cards providing feedback about the service. We also spoke with 11 patients and two representatives of the practice's patient participation group (PPG) on the day of our inspection. The majority of patients were positive about the service experienced. Patients said they felt the practice offered a good or very good service and staff were polite, very helpful and caring. They said staff treated them with dignity and respect. This was reflected in the National Patient Survey 2013/14 where the practice scored above the CCG average for patient satisfaction with privacy when speaking with staff. Patients felt the practice was safe, clean and hygienic. A minority of patients were less positive raising issues such as reception staff attitude, the attentiveness of clinical staff and waiting times. One patient told us that now that reception staff rotated with staff at Willow Tree Family Doctors, there was less opportunity to get to know staff and for them to get to know patients. Some patients were anxious about the impact of the planned move to a new building and merger with Willow Tree Family Doctors.

Members of the PPG we spoke with echoed the mostly positive views expressed by patients and felt the group was beneficial to the practice. We looked at the patient survey of 75 patients conducted through the group for 2013/2014 and saw that key themes related to access to appointments, waiting times, being able to see the same doctor and the impact of the planned move and merger.

We noted from the group's 2013/14 action plan a number of steps taken to address these issues. These included the practice promoting the increased use of on-line booking to create more capacity on the telephone line and the focus of staff training on improving the telephone service and helping patients get suitable appointments. It was also agreed to continue to inform and survey patients about the move to new premises in order that everyone was well prepared and to help those patients who preferred to leave the practice to find a suitable local alternative.

In the 2013/14 National GP Patient Survey, 63% of respondents said they would recommend the surgery to someone new to the area, which was below the CCG average. However, the survey showed that 94% of respondents said they had confidence and trust in the last GP they saw or spoke to which was markedly higher than the CCG average. The practice received more mixed ratings for patient satisfaction with consultations with doctors and nurses. Eighty-nine per cent of practice respondents said the GP was good at listening to them while 72% said the GP gave them enough time, which was below the CCG average. Only 56% of respondents said the nurse was good at listening to them and 57% said the nurse gave them enough time, both of which were below the CCG average. The practice felt that these ratings were due mainly to the nurse being new at the time of the survey and were confident that a much better rating would be achieved at the next survey.

Areas for improvement

Action the service MUST take to improve

- Arrange a programme of regular infection control audit of the practice, and ensure all staff have received up to date infection control training in line with national guidance. In addition, the practice should carry out and document an assessment of the risk of Legionella in line with national guidance.
- Complete a health and safety and fire risk assessment of the building and environment to help ensure patients, staff and visitors are sufficiently protected from the risks associated with unsafe or unsuitable premises.

Action the service SHOULD take to improve

- Arrange for all staff to complete formal training in safeguarding of vulnerable adults.

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- Complete a documented risk assessment stating the rationale for the decision not to carry out a criminal records check for non-clinical staff.
- Communicate the practice's chaperone policy more clearly to patients.
- Arrange for non-clinical staff who occasionally act as chaperones to undergo a criminal records check.
- Ensure the monthly check of medicine expiry dates is recorded.
- Ensure regular checks carried out on medical emergencies equipment are recorded. In addition, staff trained to deal with medical emergencies should receive update training to fully meet UK Resuscitation Council guidelines.
- Record weekly fire alarm system checks and implement a planned schedule of fire evacuation drills.
- Ensure following clinical audits the practice reviews whether care has improved by repeating clinical audits and thereby completing the full audit cycle.
- Document regular clinical governance meetings and administrative staff meetings to help track agreed actions and review progress at subsequent meetings. Record in the minutes evidence of the communication throughout the year of lessons learned from complaints.

Fryent Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and the team included a second CQC Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP and Expert by Experience were granted the same authority to enter Fryent Medical Centre as the CQC inspectors.

Background to Fryent Medical Centre

Fryent Medical Centre provides primary medical services to around 2,100 patients in the Kingsbury area of North West London. It is run by Willow Tree Family Doctors, a larger practice nearby. Plans are underway to merge the two practices and move to larger newly built premises around a mile away. The patient population includes a cross-section of socio-economic and ethnic groups. The practice serves a young population group with above national average numbers of patients in the 25-39 and 50-54 years age ranges.

Four partner GPs from Willow Tree Family Doctors work in rotation at the practice each day. An associate GP also works at the practice every Wednesday and Thursday. A timetable of their surgeries is on display at the reception desk for the calendar month. The practice does not employ locum doctors. A nurse works at the practice on Tuesday and Thursday each week and a health care assistant provides a phlebotomy service two days a week. The administrative team comprises a practice manager and assistant practice manager who divide their time between Willow Tree Family Doctors and Fryent Medical Centre. They are supported by five receptionists who work on rotation at the practice.

Appointments are available from 9.00am – 12.00 noon and 3.30pm – 6.30pm Monday, Tuesday, Wednesday and Friday and 9.00am – 12.00 noon on Thursday. The practice operates extended hours on Monday 6.30pm – 7.15pm and Friday 6.30pm – 7.00pm. Appointments can be booked up to three weeks in advance in person, by phone or online. Patients are encouraged to see the same doctor each time but can request any doctor or nurse working at the practice. Home visits are available to patients who are housebound or too unwell to attend the surgery.

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

There are out-of-hours (OOH) arrangements in place with an external provider. Patients are advised that they can also call the 111 service for healthcare advice.

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with Brent Clinical Commissioning Group (CCG), NHS England and Healthwatch. We carried out an announced visit on 23 October 2014.

During our visit we spoke with a range of staff including a partner GP, the practice nurse, practice manager and assistant practice manager and a receptionist. We spoke with 11 patients who used the service and two representatives of the practice's patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 32 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed information that had been provided to us prior to and at the inspection and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, audits and risk assessments and related action plans, staff records and health information and advice leaflets.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety; f example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses; for example, an error in record keeping had led to a patient being incorrectly called for an appointment. The incident had been recorded and the practice had taken immediate action to rectify the error and bring the matter to the attention of all staff, setting out the steps to take to avoid a recurrence of such an error. All patients we spoke with during the inspection told us they felt safe in the care of the doctor and nurses at the practice.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). There was a nominated lead GP responsible for reviewing and distributing any alerts and guidelines to medical staff within the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and staff we spoke with were aware of the process to follow to report significant events within the practice. The practice kept records of significant events and each was investigated noting details of the significant event, action taken, the outcome and any learning for the practice. There were no significant events in 2013/14 but the practice submitted in pre-inspection evidence an analysis of those that occurred in 2012/13. Significant events were reviewed at the practice's weekly clinical meetings and at an annual review meeting. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. In one case, a clinical coding error on the computer system had led to a delay in diagnosis for one patient. This came to light when a GP reviewed the patient's record several months later. The error was corrected immediately and appropriate checks started with the patient Clinicians were reminded of the importance of exercising care in recording clinical codes.

Reliable safety systems and processes including safeguarding

The practice had appropriate safeguarding policies in place for both children and vulnerable adults, including contact details for local safeguarding agencies. The practice had a nominated GP lead for safeguarding and staff we spoke with knew who the lead was, how to recognise signs of abuse and the process to follow and who to contact if they suspected abuse. Staff training records indicated that all but one of the non-clinical staff had completed up to date child protection training. Nursing staff received child protection training at level 2 and GPs at level 3 in accordance with national guidance. The majority of staff had not completed formal training in safeguarding of vulnerable adults. However, we were shown certificates for the practice manager and GP safeguarding lead who had completed this training.

The practice was part of the Brent Multi-Agency Safeguarding Hub (MASH). This provided a secure email address for sending safeguarding information and concerns.

A chaperone policy was in place and was on display in the consultation rooms. However, there was no information for patients about this at the reception desk or waiting room and none of the patients we spoke with were aware of the policy. Clinical staff told us that they would offer patients a chaperone when an intimate or personal examination was being undertaken. Where possible a nurse acted as the chaperone but if they were not available a member of the reception staff occasionally undertook this role. Staff we spoke with understood their responsibilities when acting as chaperones. However, non-clinical staff who occasionally acted as chaperones during intimate or personal examinations had not undergone a criminal records check.

Medicines management

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

The practice nurse maintained medicine stock records and monitored medicine expiry dates. Computer records were kept which flagged when medicine was due to expire. The

practice nurse told us they checked these records monthly., No record was made of the check currently but the practice was devising a spreadsheet for this. All the medicines we checked were within their expiry dates.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. Repeat prescriptions could be ordered, by post, online or in person at the practice. Patients were asked to allow 48 hours for repeat prescriptions to be processed before collection. Patients with repeat prescriptions were advised that the practice would need to see them to arrange monitoring tests at regular intervals, and to look out for instructions with the prescription and keep their checks up to date. If they went beyond the review date, the practice computer system was set up not to issue any further repeat prescriptions until the review had taken place. We saw records of the reviews carried out which included recommendations for action where appropriate. The records showed where the number of medicines had been reduced.

The practice nurse was not qualified as a nurse prescriber, so patient group directives (PGDs) were in place in line with relevant legislation. PGDs allow specified health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. All the necessary PGDs were signed as required by both by the practice nurse and GP prescribing lead and a folder was kept at the practice containing up to date directives.

There was a system in place for the management of patients who had been prescribed high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice said There were regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions.

Patient records were flagged to identify when patients were due for a medicines review and arrangements were made for them to attend the surgery or receive a home visit for this if they were housebound.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice had a cleaning contract in place which included a detailed cleaning specification. We saw there were cleaning schedules in place and cleaning records were kept. A cleaning manager visited the practice monthly to check the cleaning specification was being met, which the practice signed off. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

A practice nurse based at the provider's other location, Willow Tree Family Doctors, was the lead for infection control covering both locations. The infection control lead had undertaken further infection control training in May 2014 to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and ongoing updates thereafter. At the time of the inspection, we saw certificates on the practice's computer system that showed that two reception staff had last attended infection control training in 2012 and the assistant practice manager was booked to attend in January 2015. However, we were unable to view certificates showing that other staff had received recent training. We were told there were limited places available for training within the local CCG. However, the practice enrolled staff on available training dates as they arose. We were told there were limited places available for training within the local CCG. However, the practice enrolled staff on available training dates as they arose.

There was no programme in place for the regular audit of infection control within the practice. This was not in line with the Department of Health's 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance'. The practice manager informed us that arrangements had recently been made with the infection control lead for the local Clinical Commissioning Group to visit the practice shortly after our inspection to carry out an audit.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Requires improvement

Are services safe?

Information reminding staff about effective hand washing techniques were displayed within the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had not carried out and documented an assessment of the risk of Legionella (a germ found in the environment which can contaminate water systems in buildings). This is not in accordance with the Department of Health's 'The Health and Social Care Act 2008: Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance'. In section 2.3 of the code, there is a requirement for service providers to ensure they have in place adequate policies to minimise the risk of Legionella by adhering to national guidance.

Clinical waste was stored appropriately and a contract was in place for its collection and disposal.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date in January 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment completed in October 2014; for example weighing scales, nebulisers, spirometers, pulse oximeters, and blood pressure monitors.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We spoke with the most recently recruited member of staff who confirmed that the recruitment policy had been applied appropriately on their appointment.

The practice had taken the decision not to carry out DBS checks for non-clinical staff on the basis that they did not have unsupervised contact with patients. However, a documented risk assessment identifying and minimising any risks had not been undertaken stating the rationale for this decision. This was especially pertinent in relation to non-clinical staff who carried out a chaperoning role.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

The practice had a health and safety policy. Health and safety information was displayed for staff and patients to see. The practice carried out visual inspections of the premises and equipment on a daily basis. However, these checks were not routinely documented and the practice had not conducted a recent health and safety risk assessment of the building and environment to ensure patients, staff and visitors were fully protected from the risk of unsuitable or unsafe premises.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, we were shown a smear test audit completed for the six months prior to October 2014. These audits were completed twice a year. The latest audit identified no inadequate smears but the report recorded that the practice was running lower than normal regarding its QOF target, and priority would be given to achieving the target by the end of 2014/15. We also saw a recent review of prescribing to patients of high dose inhaled corticosteroids (ICS) used for the long term control of asthma. The action plan from the review included inviting all patients who had been on high dose ICS and who had not had attempt at dose reduction in the last three months for a review.

The practice used BIRT2, a risk stratification tool approved by the CCG to support practices in case managing their high risk patients. For example, the tool had been used in relation to unplanned hospital admissions to establish a case management register and put care plans in place for at risk patients. Patients on the register were written to informing them of their named GP and care co-ordinator.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including access to oxygen, a pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and we saw that all of the equipment was operational. We were told that monthly checks were carried out on the equipment but no record was kept of these checks to confirm this. Staff had received training in dealing with medical emergencies, although we noted three administrative staff were last trained in 2012 and therefore required update training to meet UK Resuscitation Council guidelines.

The provider had an appropriate business continuity plan which covered both of its locations. This set out the arrangements to be followed in the event of major disruption to the practice's services. The plan was dated 2012 and we were told that it was currently being reviewed. In the event of major disruption to the service the business continuity plan made provision for continuance of the service from the provider's other location, Willow Tree Family Doctors.

The practice had a fire safety policy in place which staff were required to read and sign as part of the induction process. However, the practice had not carried out a recent fire risk assessment of the premises. We were told staff tested the fire alarm system weekly but this was not recorded. There was no planned schedule of fire evacuation drills and none had taken place recently. The practice ensured, though, that staff were aware of the assembly point outside of the building in the event of an evacuation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. The GPs kept up to date with relevant professional guidance through continuing professional development. In addition to the process in place for disseminating guidelines from the National Institute for Health and Care Excellence (NICE) within the practice, practice nursing staff attended Nurses in Practice (NIPS) study days every two months to update their skills and knowledge. Care planning and management of individual patients and groups of patients with specific conditions was reviewed at weekly clinical meetings. All clinical staff attended these if they were available, including nursing staff if nurse-related issues were being discussed. There were also regular education sessions at practice meetings to update clinicians on the latest guidance. For example, we saw the presentation slides from a meeting in April 2014 in which case studies were discussed regarding treatment of sexually transmitted diseases.

The GP we spoke with told us there were GP leads for each enhanced CCG contracted service such as cardiology, end of life care, avoiding unplanned admissions, learning disability health checks and facilitating timely diagnosis of dementia. Nursing staff led smoking cessation and chlamydia services. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on the basis of need alone in this decision-making process.

Management, monitoring and improving outcomes for people

The practice routinely gathered information about people's care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess performance and carried out regular clinical audit. The QOF is a national group of indicators, against which a practice scores points according to their level of achievement in the four domains of clinical, organisation, patient experience and additional services. QOF data showed the practice performed above other practices in the local CCG area in the majority of indicators in the year ending April 2014.

We noted that the practice performance in the QOF reports for 2013-2014 showed a total of 99.8 % of QOF points achieved in the clinical domain which was above the CCG average. We noted that for the majority of these indicators the practice achieved above the CCG average (100% in several areas) and for one indicator only, learning disability, below the CCG average. Within the domains of organisation, patient experience and additional services, the majority of practice scores were above or equal to the CCG and national averages.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits undertaken in the last 12 months included audits of prescribing of silver dressings for wound care; prescribing of high dose inhaled corticosteroids (ICS) used for the long term control of asthma; and cervical screening smears. Some actions for improvement had been identified as a result of the audits. For example, in the silver dressings audit, agreed action was to circulate an in-house message reminding clinical staff of the dressings formulary (a process to support the management of dressings) and to make it readily available on the practice intranet to facilitate its ease of use. However, it was not readily evident that action resulting from initial audits had been systematically monitored and reviewed further to test its effectiveness and complete the full clinical audit cycle. We were told audits were reviewed at clinical meetings. However, the weekly meetings were not formally minuted so the practice was unable to provide documentary evidence to demonstrate this.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had identified a register of patients with asthma and had used this information to invite identified patients for a health review. Eighty-four percent of these patients had been reviewed in the preceding 12 months.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example, the practice participated in an external peer review with other practices in the CCG area to compare its data on emergency hospital admissions and data on accident and emergency attendances.

We noted the practice participated in enhanced service schemes to improve the management and delivery of care

Good

Are services effective?

(for example, treatment is effective)

to specific patient groups. For example, under an enhanced service patients with learning disabilities were reviewed annually and received a physical health check, medicines review and blood and other screening tests. Three of eight patients on the register received a review in 2013/14. More recently, planned reviews had not taken place because patients had failed to attend appointments arranged. However, the practice had sent out further appointment invitations to secure their attendance.

Effective staffing

The GPs who worked at the practice kept their skills up to date through regular training and continuing professional development. The GP we spoke with said the GPs had undertaken appraisals and were up to date with or were soon due for their revalidation.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. We saw on staff records that appraisal reports had been completed for all but one of these staff for the current reporting year. Staff we spoke with confirmed they had received an appraisal. This included the opportunity to discuss and agree their personal learning and development needs and they had continued to undertake relevant training throughout the year.

Staff did not receive formal supervision but said they could access a manager or their mentor for advice whenever they needed to. Nursing staff attended the practice's clinical meetings when they were available. The managers of the administrative team arranged ad hoc meetings for non-clinical staff if important information or developments needed to be cascaded. There were also monthly meetings to provide in-house training and briefing, for example on the new practice clinical computing system and the management of the annual flu campaign.

The practice had appropriate human resource policies and procedures in place including, recruitment, discipline, appraisal, staff competencies and evaluation, anti-discrimination and whistleblowing. The practice also had policies for dealing with patients at reception (including the panic alert process on the clinical computer system). Separate clinical practice policies and procedures were also accessible to all staff. All policies were regularly reviewed and were available on the practice intranet.

All the staff we spoke with said they felt equipped to do their job and were supported in their role.

Working with colleagues and other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach to meet patients' needs and manage complex cases.

The practice facilitated patients' access to the local 'Improving Access to Psychological Therapies' (IAPT) programme which provided self-help courses for patients with common mental health difficulties such as stress, worry and low esteem. An IAPT counsellor was available on site to provide counselling and psychology services and patients were referred by their GP or could ask for a referral.

There was an effective system in place for arranging and reporting the results of blood tests, x-rays and smear tests for example. This included a timely follow-up system to ensure these had been seen by the GP on the same day and actioned. Results were usually received electronically. The practice provided a phlebotomy service twice a week and appointments could be booked via the blood test request form.

The practice held regular meetings with health visitors in the children's centre next door to the practice.

The practice had out-of-hours (OOH) arrangements in place with an external provider. Patients were advised that they could also call the 111 service for healthcare advice. The OOH service shared information about any care provided to practice patients electronically with the practice the next day. This was reviewed by the duty GP in case further action was needed.

We were told patients were offered some choice about referrals for hospital appointments and community services. However, the majority of patients were referred under the Brent 'Referral Facilitation Service' (RFS). The purpose of the service was to ensure all patient referrals were directed to the most appropriate clinician. The practice also used the national 'Choose and Book' service for urgent referrals or those requiring a two week wait. The GP booked referrals through the service in the presence of patients after discussion of the options available. If patients wished to check the status of their referral and change or cancel their appointments they could request a password for doing so.

The practice had an effective process in place to follow up patients discharged from hospital. Discharge summaries were received electronically and were followed up by a GP.

Good

Are services effective?

(for example, treatment is effective)

The practice participated in a local enhanced service (LES) for unplanned admissions, reviewing discharged patients to determine if a hospital admission had been necessary. Care plans had been put in place for patients on the case management register for patients at risk of hospital admission. By pass telephone numbers were allocated to enable them to receive same-day telephone consultations or follow-up arrangements where required where they have urgent queries. The practice used the Brent Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) system which includes a multi-disciplinary team of nurses, physiotherapists, consultant physician, dieticians, speech and language therapists and healthcare support workers, supported by the SPA (Single Point of Access) team who manage the administration. Patients in crisis or at risk of hospital admission were given a comprehensive clinical assessment at home within two hours of referral. The team liaised closely with GPs and the team consultant in order to provide immediate clinical care, rehabilitation and social support.

The practice was involved in the North West London 'Whole Systems Integrated Care' programme to ensure better co-ordinated care for patients with complex conditions. They were also part of a local pilot for the integration of health and social care for patients.

The practice held regular meetings with district nurses, care-coordinators, palliative care and health visitors to help establish best care for patients with long term conditions. Increased patient autonomy and self-care was encouraged by providing patients with information on self-care, including printed material, web-site access and sign-posting to self-help groups.

The practice provided effective end of life palliative care. The practice worked closely with the local hospice for people receiving palliative care. There were regular multidisciplinary meetings to review patients on the practice's end of life care register, including palliative care nurses, district nurses and health visitors.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local OOH provider to enable patient data to be shared in a secure and timely manner.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a comprehensive consent policy which set out why consent was crucial; what constituted consent; types of consent; obtaining consent**;** The Mental Capacity Act (2005); what information should be provided; recording consent; consent for children; obtaining written consent; and the patient consent procedure form. Staff understood the policy and confirmed they would always seek consent before giving any treatment.

We found that clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. The practice tried to involve relatives, friends or advocates where possible, where mental capacity was an issue. However, the practice recognised that this was an area for further development within the practice, especially in relation to understanding of capacity assessments and Deprivation of Liberty Safeguards (DoLs). Clinical staff demonstrated an understanding of Gillick competencies when asked about seeking consent. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

For significant procedures, staff recorded a patient's agreement to the procedure and the discussion leading to that agreement on a consent form which was scanned into the patient's notes. Any changes to a form, made after the form had been signed by the patient, were initialled and dated by both patient and the clinician.

Health promotion and prevention

There was a range of information available to patients in the waiting area which included leaflets which could be taken away from the practice. There was also helpful information on the practice website which provided links to the NHS Choices Website, and the most popular health subjects. There was also a 'Live well' section which provided advice on a variety of subjects including immunisation, stopping smoking, the 'Get fit for free scheme', guide to 'early year' parenting, mental health and contraception.

Good

Are services effective?

(for example, treatment is effective)

The practice offered all patients in the 45-74 age group a health check. All newly registering patients were invited to a new registration consultation with the practice nurse to help identify and plan their medical needs. Patients with a learning disability were offered a physical health check.

The practice provided 'well person' checks, carried out by appointment with the practice nurse. Health and exercise advice was given at routine appointments. Seasonal health advice was provided on the practice's website to help patients take care in hot or cold weather, together with links to support services. The practice offered a smoking cessation service.

For patients approaching retirement the practice discussed opportunistically their plans and encouraged them to adopt a structured life-style, exercise, good diet and identified potential risk of depression and relationship stresses due to their changing role, and suggested volunteering as an option.

The practice proactively encouraged patients' increased autonomy for better self-care. For example, they tried to empower patients with long term conditions as much as possible providing information on self-care, printed material, website links and self-help groups. Doctors and nurses provided dietary advice and printed information for patients on healthy eating. Patients were referred to a dietician for additional support where appropriate.

The practice provided contraception and sexual health services including contraception advice and emergency contraception, smear testing and chlamydia screening. All patients, including street sex workers could register with the practice and a GP could refer them to a local genitourinary medicine (GUM) clinic for sexual health screening. The practice's performance for cervical smears was 83% in 2012/13 which was better than the average of 79% for the CCG area. In the same period the performance for breast screening was 73% which was better than the CCG average of 64%.

The practice offered a full range of immunisations for children. Flu vaccination was offered to patients over the age of 65 (70% uptake in 2013/14, marginally below the national average of 73%), those in at-risk groups (including patients with long-term conditions) and pregnant women. The practice also offered pneumococcal vaccinations to patients over age 65 and those at higher risk due to other illnesses and medical conditions. The practice offered a full travel vaccination service including yellow fever vaccinations.

The practice participated in a 2014/15, CCG commissioned direct enhanced service (DES) for dementia. GPs identified patients at risk of dementia and referred them to a specialist memory clinic. This was followed up by a six-month assessment on patients with a dementia diagnosis who had been discharged from the memory clinic.

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 2013/14 National GP Patient Survey and a survey of 75 patients undertaken by the practice's patient participation group (PPG). The evidence from the national survey showed the practice was rated 'among the best' for patients who said they had confidence and trust in the last GP they saw or spoke to. The practice received more mixed ratings for its satisfaction scores on consultations with doctors and nurses. Eighty-nine percent of practice respondents said the GP was good at listening to them while 72% said the GP gave them enough time, which was below the CCG average. Only 56% of respondents said the nurse was good at listening to them and 57% said the nurse gave them enough time, both of which were below the CCG average. The PPG survey did not ask the same questions but overall 83% of patients surveyed were satisfied with their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority were positive about the service experienced. Patients said the practice offered a good or very good service and staff were polite, very helpful and caring. They said staff treated them with dignity and respect. Eight comments were less positive raising issues such as reception staff attitude, the attentiveness of clinical staff and waiting times. We also spoke with 11 patients and two members of the PPG on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. This was reflected in the National GP Patient Survey 2013/14 where the practice scored above the CCG average for patient satisfaction with privacy when speaking with staff. One patient told us that now that reception staff rotated with staff at Willow Tree Family Doctors, there was less opportunity to get to know staff and for them to get to know patients.

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

The practice reception desk and was shielded by glass a partition which helped keep patient information private. The location of reception in a corridor made maintaining privacy and confidentiality more challenging. However, reception staff told us they took patients to an area away from other patients if they needed to discuss matters in privacy. We observed that confidentiality was appropriately maintained at reception during our inspection.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the practice scored below the CCG average to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the National Patient Survey 2013/14 showed 70% of practice respondents said the GP and 48% the nurse they saw or spoke to was good at involving them in decisions about their care. 84% felt the GP was good at explaining treatment and results which was above the CCG average but only 54% felt this about the nurse they last saw or spoke to which was below the average compared to the CCG area.

The majority of patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to ask questions and make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also mostly positive and aligned with these views. However, two of 32 patients felt a lack of involvement and attentiveness by the clinical staff.

Patients were advised that an interpreter service could be booked for patients whose first language was not English to help them with their communication needs. The practice leaflet provided information informing patients this service was available. We noted also the practice's website had a translation facility for each page in a wide choice of languages.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with were positive about the emotional support provided. One patient we spoke with told us the doctors and nurses had supported them to change their lifestyle and this had a big impact on their well-being.

The practice provided effective end of life palliative care. The practice worked closely with the local hospice for people receiving palliative care. There were regular multidisciplinary meetings to review patients on the practice's end of life care register, including palliative care nurses, district nurses and health visitors. The practice provided copies of the notes of recent meetings and we saw that discussion included recent deaths and a review of the care planning and update of plans for each patient on the register. We noted an entry by a patient's relative on the NHS Choices website commenting on the exceptional care provided by the practice during the last few weeks of the patient's life.

Notices in the patient waiting room, also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs. The needs of the local population were understood and services were in place to meet them. There was extended opening on Monday and Friday to meet the needs of working age patients. The evening opening hours met the needs of parents with school children and those in education.

It was not always possible for the practice to achieve continuity of care. Patients said sometimes it was difficult to see the GP of their choice. This was reflected in the National GP Patient Survey 2013/14 where the practice scored below the CCG average for patients with a preferred GP who usually get to see or speak to that GP. There were also comments about this in the 2013/14 patient survey run by the practice. Seventy-seven percent of patients agreed continuity of care was important and around half reported they were "mostly" able to see their preferred choice of doctor and a further 30% at least some of the time. The practice acknowledged that as the doctors worked across two practice locations, it was difficult to provide continuity of GP. But this was expected to improve when the practices merged. To improve matters in the meantime, the practice put a timetable of the individual GP's surgeries on display at the reception desk for the calendar month to give patients some opportunity to make an appointment with the GP of their choice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, in response to comments on the difficulty of getting appointments over the telephone, the practice promoted the increased use of on-line booking to create more capacity on the telephone line. The practice also undertook to focus staff training on improving the telephone service and helping patients get suitable appointments.

The practice had three male and two female GPs and was able to offer choice of male or female doctor if this was requested in advance. Longer appointments were available for people who needed them and those with long term conditions.

The practice's midwifery service previously provided by the local NHS Hospital Trust had been withdrawn. However, the practice now offered shared ante natal care in partnership with a children's centre immediately next door to the practice. Doctors and the practice nurse provided baby immunisations. Most child health checks were provided by health visitors at the children's centre. Easy access was available for children and parents/responsible adults could phone the practice for advice and be provided with same day appointments for children.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients' and their families' care and support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had an open policy regarding registrations. For example, there were two homeless persons on the practice's register and travellers from a visiting fun fair had been temporarily registered. The practice also received patients with drink problems who had been referred by Adaction, a specialist drug and alcohol treatment charity.

Quick access appointments were available for vulnerable patients, for example if they turned up without a booked appointment.

The practice had access to an interpreter service and could book a trained interpreter on behalf of patients or they could phone for assistance themselves.

The premises and services had been adapted to the needs of patients with a disability. There was disabled parking and level access from the main entrance for wheelchair users. The toilet facilities had been modified to accommodate patients with a disability. The practice was on two levels and patients who had difficulty in climbing stairs were seen in the ground floor treatment rooms.

Access to the service

Appointments were available from 9.00am – 12.00 noon and 3.30pm – 6.30pm Monday, Tuesday, Wednesday and Friday and 9.00am – 12.00 noon on Thursday. The practice operated extended hours on Monday 6.30pm – 7.15pm and Friday 6.30pm – 7.00pm. Appointments could be booked up to three weeks in advance in person, by phone or

Good

Are services responsive to people's needs?

(for example, to feedback?)

online. Patients were encouraged to see the same doctor each time but could request any doctor or nurse working at the practice. Home visits were available to patients who were housebound or too unwell to attend the surgery.

Comprehensive information was available to patients about appointments on the practice website. This included how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Details were also made available of the local NHS walk in centre that was open between 7.00am and 10.00pm seven days a week.

Patients' satisfaction with the appointments system varied. The views from patients we spoke with and who completed comment cards were mostly positive about access to the service. However, there were some negative comments about the difficulty in getting an appointment and getting through to the surgery on the telephone during busy times.

Data from the 2013/14 National GP Patient Survey showed 89% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, which was above the CCG average. Eighty percent said their last appointment was convenient and 61% described their experience of making an appointment as good. Both of these scores were below the average for the CCG area.

The data from the latest patient survey conducted by the practice's patient participation group (PPG) showed 43 of the 75 respondents described phone access as good or very good and three as poor. 52 respondents were able to make an appointment within two working days but 11 were not. Alternative appointments were offered to 33 respondents but 12 described no appointment being offered. Only two respondents booked online, six were aware that they could book ahead three weeks and 25 thought they could only book on the day. The action plan from the survey included steps to promote increased use of on-line booking to create more capacity on the telephone line and a focus staff training on improving the telephone service and helping patients get suitable appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. The practice manager dealt with non-clinical complaints and the lead GP partner clinical complaints.

We saw that information was available to help patients understand the complaints system. There were copies of the practice's complaints leaflet in the waiting area which set out the complaints procedure and timescale and provided information about who to contact for additional advice. There was also a suggestion box in the waiting room where patients could make suggestions or comments which the practice reviewed daily. There was also information about making complaints on the practice website. None of the patients we spoke with had needed to make a complaint about the practice.

We looked at the eight complaints included in the practice's 2013/14 complaints report and found these were appropriately handled and dealt with in a timely way. The complaints report was used by the practice at its annual complaints and significant events meeting to review all complaints to identify themes or trends. The analysis included a summary of the complaint, a detailed analysis and outcome and action where appropriate in the light of the results. We saw from individual complaints records that the response included an explanation and apology and where appropriate stated what action the practice had taken in the light of lessons learned to avoid a future recurrence. For example, in one case of a complaint about the appointments system, training needs for 'front of house' staff were identified regarding making appointments and relaying accurate information to patients. This was implemented through the practice's in-house monthly staff training sessions.

Staff we spoke with told us they attended the annual complaints review meeting where learning points were identified and discussed. We were told also that lessons learned were communicated throughout the year when individual complaints were concluded, for example at the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice's monthly meeting in-house training meetings. However, these meetings were not documented to evidence ongoing shared learning from complaints outside of the annual review meeting.

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 clear ethos which involved putting patients first and was committed to providing them with the best possible service working in partnership with them. Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England. The practice's statement of purpose set out in detail the service's aims and objectives for all outcome areas within the current regulations. Not all staff were aware of this statement and it was not on display for patients. However, all staff were able to articulate the essence of the stated aims and it was clear that patients were at the heart of the service they provided. The practice prided itself on providing a family orientated service and patient feedback indicated that patients favoured this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer intranet within the practice. We looked at a range of these policies and procedures and saw that staff were required to complete and sign a comprehensive list to confirm that they had read each. The policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data showed the practice performed above other practices in the local CCG area for the majority of indicators in the year ending April 2014. We were told QOF data was regularly discussed at weekly clinical meetings and action plans were produced to maintain or improve outcomes. For example, an audit of cervical smears recorded that the practice was running lower than normal regarding its QOF target, and the practice took action to give priority to achieving the target by the end of 2014/15.

The practice took part in a local peer review system within the network of neighbouring GP practices, which gave the practice the opportunity to measure its service against others and identify areas for improvement. We were told that at recent meetings performance had been reviewed and compared from prescribing audits, smoking cessation and chlamydia screening.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits in the last 12 months included audits of prescribing silver dressings for wound care; prescribing of high dose inhaled corticosteroids (ICS) used for the long term control of asthma; and cervical screening smears. The practice also undertook bi-monthly prescription audits and we saw from the records of these audits that where appropriate, follow up action was identified, for example to take a patient off repeat prescribing and give them an injection instead to treat a dietary deficiency.

The practice had arrangements for identifying, recording and managing risks. The practice had a business continuity plan, to respond to and manage risks in the event of major disruption to the service. The practice also regularly monitored and reviewed risks to individual patients, using specific risk assessment and management tools where appropriate, and updated patient care plans accordingly.

The practice held weekly clinical governance meetings to discuss performance, quality and risks but these were not minuted, so we were unable to see documented evidence of the issues discussed and action agreed. This also meant that information relating to agreed action might not be readily retrievable to enable progress to be reviewed from one meeting to another. We were, however, provided with copies of the documentation for the practice's annual strategy meeting for the last two years. We saw from the 2014/15 meeting that the practice had carried out a SWOT analysis identifying the strengths, weaknesses, opportunities and threats to the different service areas, including clinical, administrative, financial and staffing services. Action points from these meetings were recorded identifying immediate risks to the service and the clinical lead responsible for the action. For example, the commencement of identification of patients at risk of unplanned hospital admission, using a specific risk assessment tool. We saw also the strategy meetings were used as education meetings to update clinicians on a range

Are services well-led?

Good

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

of issues including for example, the new out of hours contracts for insulin, cardiology, carers and end of life care introduced in 2014/15 in place of previous local enhanced services.

The practice's current business development plan was centred around the move of the practice to new premises in 2015/16 when it will merge with the provider's other location. The practice was working closely with the PPG on the move, the associated planning and communication with patients. Regular update bulletins were being posted on the practice website.

Leadership, openness and transparency

In addition to weekly clinical meetings, administrative staff met weekly or fortnightly to be briefed on operational issues and developments. They also held monthly training meetings to receive training and instruction on working practices, for example as a result of lessons learned from complaints. However, none of these meetings were minuted, which meant that information relating to agreed action might not be readily retrievable to enable progress to be reviewed from one meeting to another. However, staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues on a day to day basis and in regular informal meetings with their managers.

The practice manager was responsible for human resource policies and procedures including equal opportunities, sick absence, whistleblowing grievance and discipline. We reviewed a number of policies, for example recruitment, induction and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies, if required, which were available on the practice intranet.

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

The practice had gathered feedback from patients through patient surveys, a suggestion box, the NHS Choices website and complaints received. We saw as a result of patient feedback the practice had extended the operating hours by remaining open over lunchtime and introducing extended evening times on Monday and Friday. The practice was unable to investigate the comments posted on NHS Choices as the majority were anonymous. However, the comments were reviewed within the practice and any negative feedback addressed as far as possible, for example in one case by offering staff more training. The practice had also responded to all postings shortly before the inspection offering an explanation and an apology or meeting or telephone call to discuss the matter further where appropriate in response to negative comments.

The practice had an active patient participation group (PPG). With the planned move to new premises in 2015/16, the group had recently joined with Willow Tree Family Doctors to form a single PPG. Committee meetings were held every two months. The practice ran an annual patients survey in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The latest patient survey report for 2013/14 noted that the take up of on-line booking of appointments through the practice's website had been relatively small. As a result the practice was promoting increased use of on-line booking to create more capacity on the telephone line. For example, when new patients handed in their registration form, they were encouraged to register for on-line booking. Patients who reported that they had found it difficult to make a telephone booking were also signposted to this service. The practice also ran a PPG annual general meeting which was open to all patients and provided an opportunity to catch up on practice news and the changes in the NHS that would affect patients and their families.

The practice had gathered feedback from staff generally through staff meetings, appraisals and day to day informal discussions. Staff told us their managers were approachable and they felt free to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff via the practice's intranet. Not all staff we spoke with were aware of the policy. However, they knew who to go to if they wished to report any concerns.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents and shared lessons learned with staff

Are services well-led?

Good

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

via meetings to ensure the practice improved outcomes for patients. For example, there was a breakdown in communication which led to a delay in a patient's referral to hospital. As a result reception staff were reminded that all urgent referrals sent by fax must be followed-up with a phone call to check the fax has been received and documented in the patient record. Doctors were asked to ensure they informed patients of approximate waiting times so patients can contact the surgery if they had not heard from the hospital in a given timescale.

This section is primarily information for the provider

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The provider must take steps to ensure patients and staff are sufficiently protected from the risk of infection by the effective operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections. Regulation 12 (1) and (2) (a).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises because the practice had not carried out recent health and safety or fire risk assessments of the building and environment. (Regulation 15(1)(a) and (b)).