North Street Medical Care

Quality Report

274 North Street
Romford, Essex
RM1 4QJ
Tel: 01708 629 733
Website: www.northstreetmedicalcare.co.uk

Date of inspection visit: 17 March 2015
Date of publication: 06/08/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at North Street Medical Care on 17 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services. It was also good for providing services for older people, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, people experiencing poor mental health (including people with dementia) and for people with long term conditions.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect; and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly, the provider should:

Summary of findings

- Undertake a risk assessment for legionella (a bacterium which can contaminate water systems in buildings).
- Review its systems so that learning from significant events is also shared with non clinical staff.
- Consider introducing equality diversity and human rights training for staff.
- Continue to work with its Patient Participation Group to monitor and improve telephone access as necessary.
- Introduce a systematic programme of clinical audit to drive improvements in patient outcomes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses (including safeguarding concerns). Lessons were learned to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe. Risks to patients and staff were assessed and well managed (for example infection prevention and control audits). However, we noted that not all non clinical staff had undertaken basic life support training within the last twelve months.

Are services effective?

Good

The practice is rated as good for providing effective services. Data we looked at before our inspection showed that patient outcomes were at or above average for the locality in areas such as childhood immunisations and uptake of seasonal flu vaccine for patients aged 65 and older.

Peoples' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams and used guidance from the National Institute for Health and Care Excellence (NICE) to improve patient outcomes. We saw evidence that clinical audits were being used to help improve patient outcomes (for example regarding safeguarding of children).

Are services caring?

Good

The practice is rated as good for providing caring services. Patient satisfaction (in terms of GPs treating patients with care and concern) was higher than other Havering practices. Feedback was also positive regarding the helpfulness of reception staff and peoples' involvement in decisions about their care. Patients told us they were treated with compassion, dignity and respect. They also told us that doctors and nurse provided sufficient information to be able to make informed decisions about their care and treatment. We saw that staff treated patients with kindness and respect. Patients told us that staff ensured that patient privacy and confidentiality were maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It was well equipped to treat patients and meet their needs. The practice had good physical facilities such as wheelchair access and

Summary of findings

baby changing facilities. Longer appointments were offered for those that needed them and we saw that language interpreting (including British Sign Language) was available. Information about how to complain was available and easy to understand. We also saw evidence that the practice learned from complaints and used this information to improve the service. Patient feedback was not positive regarding appointment access (particularly telephone access) but we saw evidence of how the practice had sought to address this issue.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. One of the partners was a nurse prescriber and nursing staff spoke positively about how she supported their clinical work. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had an active patient participation group (PPG) a patient led forum for sharing patients' views with the practice. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance (including the Mental Capacity Act 2005). Nationally reported data showed that the practice performed better than the Havering and England averages for assessment of conditions commonly found in older people. Seasonal flu vaccination rates for patients aged 65 and older were also above average.

We noted that the practice was responsive to the needs of older people offering, for example home visits, telephone consultations, rapid access appointments and extended appointment slots. Older patients spoke positively about how they were treated by staff. Patients aged over 75 had their own named GP and were offered annual health checks.

Records showed that the practice routinely reviewed the care of patients on its palliative (end of life) care register and that it worked with palliative care nurses in the care and treatment of patients as part of a multidisciplinary approach. Partner GPs and the partner nurse prescriber undertook weekly visits to two local nursing homes and also organised quarterly multi-disciplinary meetings to support staff in medicines management and advanced dementia care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We noted that 48% of patients had a long standing health condition and the practice outlined how it worked to help patients manage their conditions. Longer appointments and home visits were available when needed. The practice ran a dedicated long term conditions clinic every other Saturday. Patients had a named GP and practice nurses regularly reviewed patients on long term condition registers to check that their health and medication needs were being met.

Quality Outcomes Framework (QOF) performance data was routinely used at weekly clinical meetings to monitor and review patient outcomes. QOF is a national performance measurement tool. These meetings demonstrated use of national best practice such as NICE guidelines. We also saw evidence of how practice staff worked with other health care professionals (such as district nurses) to deliver a multidisciplinary and coordinated package of care.

Summary of findings

Patients with long term conditions told us that clinicians provided sufficient information to enable them to make informed decisions about their care and treatment. We noted that unplanned hospital admissions for long term conditions such as diabetes and lung disease were below local and national averages.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies (for example baby changing facilities were available). Practice staff were aware of local safeguarding contacts and knew how to escalate concerns.

The practice ran a drop in sexual health clinic which was particularly responsive to the needs of young patients. The practice had processes in place to prioritise seeing acutely ill children and young people. Chlamydia and HIV testing was available for young people and other population groups. The practice safeguarding lead was also the child protection lead GP for Havering Clinical Commissioning Group CCG. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. We saw examples of joint working with midwives and health visitors. We noted that the practice allocated adolescent appointments at every session; offered by a partner GP with a special interest in working with adolescents.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified; and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included early morning appointments, online appointment booking and repeat prescriptions facilities. The practice ran a long term conditions clinic every other Saturday which we noted was responsive to all patients including those of working age. The practice also offered a full range of health promotion and screening information that reflected the needs of this age group. The practice's website contained links to NHS Choices healthy living advice webpages.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances.

Patients with learning disabilities were offered annual health checks and longer appointments. We also noted that “easy read” pictorial leaflets were available, outlining various treatments and conditions. The practice offered interpreting services in a range of languages including British Sign Language (BSL).

Staff knew how to recognise signs of abuse in vulnerable adults. They were also aware of their responsibilities regarding information sharing, documenting safeguarding concerns and contacting relevant agencies in normal working hours and out of hours. The practice held regular adult safeguarding meetings to discuss patients who were particularly vulnerable and how they could be supported.

We noted that 20% of patients had a caring responsibility. We were told that the practice routinely referred patients requiring support to a local carer support network. Carers information was provided in the practice reception and on the practice website.

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 kept a register of patients experiencing poor mental health and GPs stressed the importance of reviewing patients’ physical as well as mental health. For example, the practice performed better than the Havering and England practice averages for patients with poor mental health who had a record of a cholesterol check on file in the preceding twelve months.

The practice offered flexible appointments such as evening appointments (when the practice was less busy) as we were told that this was preferred by many patients experiencing poor mental health. The practice also had systems in place to support patients presenting with acutely poor mental health and routinely referred patients with less severe symptoms to specialist local voluntary sector organisations.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and undertook weekly nursing home visits. The practice also organised quarterly multidisciplinary meetings to support nursing home staff in medicines management and dementia care.

Summary of findings

The practice advised patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice used social media, website and its waiting room screen to publicise the support available to patients and carers. We were told that this encouraged patients to seek advice and helped address the stigma sometimes associated with poor mental health.

Summary of findings

What people who use the service say

During our inspection, we spoke with three members of the practice's Patient Participation Group (PPG). They spoke positively about patient care and about how the practice listened and acted on the group's concerns.

During our inspection, we used existing patient feedback to guide our discussions with patients. For example, the NHS England GP national patient survey 2014 highlighted that only 34% of respondents found it easy to get through to the practice by phone (compared with the local Havering practice average of 73%). We spoke with six patients; all of whom shared this view. However, the practice demonstrated how they had acted on this issue: for example highlighting the recent introduction of online appointments booking to relieve pressure on telephone lines. Shortly after our inspection we were further advised that a new telephone system with additional capacity had been introduced.

Seventy seven percent of respondents described their overall experience as good.

Areas for improvement

Action the service SHOULD take to improve

- Undertake a risk assessment for legionella (a bacterium which can contaminate water systems in buildings).
- Review its systems so that learning from significant events is also shared with non clinical staff.
- Consider introducing equality diversity and human rights training for staff.
- Continue to work with its Patient Participation Group to monitor and improve telephone access as necessary.
- Introduce training for undertaking chaperoning duties.
- Introduce a systematic programme of clinical audit to drive improvements in patient outcomes.

North Street Medical Care

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP granted the same authority to enter the registered person's premises as the CQC lead inspector.

Background to North Street Medical Care

North Street Medical Centre is located in the London Borough of Havering, outer east London. The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients and is also a teaching practice.

The practice has a patient list of approximately 12,200. Approximately 21% of patients are aged 65 or older and approximately 14% are under 18 years old. Forty eight percent have a long standing health condition and 20% have carer responsibilities.

At the time of our inspection the practice opening times were 8:00am to 6:30pm Monday to Friday (except Wednesdays which were 8:00am to 12.30pm with an out of hours service provider operating between 12.30pm and 6.30pm). Telephone lines were open 8am to 12:30pm and 2pm to 6:30pm (with the out of hours service providing phone cover daily between 12.30pm and 2pm).

Appointments were available from 8:00am to 11:00am and 2pm to 5pm. After our inspection we were advised that the practice had merged in April 2015 and that from 1 June 2015 it opened Wednesday afternoons.

The practice is registered with the Care Quality Commission to provide following regulated activities: family planning; treatment of disease, disorder and injury; surgical procedures; diagnostic and screening procedures and maternity and midwifery services.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions, smoking cessation and musculo skeletal clinics. The staff team comprises six GP partners (two female, four male), one female salaried GP, nurse practitioner partner (female), one long term locum GP (male), five practice nurses (female), health care assistant, two practice managers (one covering finance/IT, one covering human resources) and a range of administrative staff.

Havering has a population of 237,000. Between 2001 and 2011 the Havering population grew by 6% (12,984 people). The total Havering population is forecast to rise to around 250,500 by 2016 and 263,900 by 2021 (representing 5.7% and 11.4% increases on the 2011 Census population respectively). Over the last ten years Havering has become more ethnically diverse. In 2001 Black and minority ethnic groups accounted for 8% of the total population; in 2011 this had risen to 17%.

The health of people in Havering is varied compared with the England average. Deprivation is lower than average, however about 8,800 children live in poverty. Life expectancy for women is higher than the England average. Comparing the most deprived areas of Havering to the least deprived areas, life expectancy is 6.9 years lower for men and 4.2 years lower for women.

Detailed findings

There is a strong correlation between poverty/deprivation and poor health, for many reasons that include poor diet/ nutrition and unhealthy living and working conditions. Havering was ranked 177th out of 326 local authorities for deprivation in the Indices of Deprivation 2010 (1st being most deprived, 326th being least deprived) and is relatively affluent compared to the London average. However, there are pockets of acute deprivation in Heaton, Gooshays, South Hornchurch and Romford wards.

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 March 2015. During our visit we spoke with a range of staff (GPs, nurse prescriber, practice nurse, practice manager and reception staff) and spoke with patients who used the service including Patient Participation Group (PPG) members. We observed how people were being cared for and talked with carers and/or family members. We also spoke with six patients.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety including reported incidents and comments/complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Clinical and non-clinical staff had a good understanding of the system and of how concerns could be escalated. The practice also had a safety alert protocol detailing the procedure for sharing received drugs alerts throughout the practice. Staff knew their roles and accountability in this process. There were effective arrangements in place to report safety incidents in line with national and statutory guidance.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We noted that 31 significant events had occurred during 2014. Records showed that these had been discussed at quarterly significant events meetings although we noted that only clinical staff attended. We saw evidence that the practice discussed significant events in some detail at the meetings and of how it had used the significant events to improve the way in which it delivered the service. For example, following a pregnancy related significant event, ante natal appointments for newly pregnant women were prioritised on the appointments system.

National patient safety alerts were disseminated by practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. For example, nursing staff recalled a recent alert advising staff of increased risk of stroke with a specific anti-inflammatory drug. Protocols were in place to contact affected patients and amend repeat prescriptions as necessary. We were told that alerts were discussed at clinical meetings to ensure that all relevant staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. GPs and nurse practitioner were Level 3 trained in child protection and had also received vulnerable adults safeguarding training. Non-clinical staff had attended basic children and vulnerable adults safeguarding training within the last three years. When we spoke with non- clinical staff they could describe possible types of abuse (including in older patients) and knew how and to whom they would report or escalate a concern. We noted that GPs had experience of contributing to serious case reviews and child protection hearings.

One of the partner GPs was the designated safeguarding lead for the practice and also the child protection named GP for the local CCG. We asked how their CCG role helped the practice safeguard patients from the risk of abuse. They told us that a recent audit of clinical note taking had been triggered by their involvement in a CCG case where a practice's patient notes had not specified who had accompanied a child to the practice.

The practice had a chaperone policy which was displayed in the waiting room and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. We were told that only clinical staff undertook chaperoning duties. They had been trained and had received Disclosure and Barring Service (DBS) checks. These identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients experiencing poor mental health.

Medicines Management

We checked medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. The practice did not hold Controlled Drugs on the premises.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and

unwanted medicines were disposed of in line with waste regulations. We noted that the practice had recently received an award from the local CCG for a publicity campaign on reducing medicine waste.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2014. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular GP supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All clinical, communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment. Consultation rooms had vinyl flooring and we noted that clinical waste was stored securely away from patient areas whilst awaiting collection. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

A practice nurse was Infection Prevention and Control (IPC) lead and was responsible for ensuring effective infection control throughout the practice. When we asked them how their infection control training had supported their role, they spoke about the importance of hand hygiene and told us that this was regularly audited. We noted that personal protective equipment such as gloves and aprons were readily available for staff to use.

The practice had an infection control policy and we noted that in accordance with the policy, infection control audits took place every six months. We looked at the action plan arising from the latest audit (December 2014) and were able to confirm for example, that sharps bins were dated and signed.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records confirming that the practice had tested for the presence of legionella bacteria in September 2014. We noted that the practice had not undertaken a legionella risk assessment but we were told that this would take place by July 2015.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Fire alarm and portable appliance testing (PAT testing) had also taken place within the last twelve months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment for example weighing scales and blood pressure measuring devices.

Staffing & 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 the appropriate checks through the Disclosure and Barring Service (these checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice had recruitment procedures in place that ensured staff were recruited appropriately. Most non-clinical staff had been employed by the practice for more than five years and we noted that for some DBS checks had not been undertaken. Non clinical staff did not undertake chaperoning duties. We noted that new staff completed an induction which included infection control & prevention, health and safety and an overview of staff members' roles. DBS checks were on file for all clinical staff. Staff told us there were usually enough staff to maintain the smooth running of the practice and we saw evidence that systems were in place to keep patients safe.

Good

Are services safe?

The practice had systems in place to ensure that staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & 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, bi-annual and monthly checks of the building and equipment, infection control, medicines management, staffing and dealing with emergencies. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Records showed that identified risks were routinely discussed at clinical meetings and partner meetings.

Arrangements to deal with emergencies and major incidents

There were sufficient systems in place to deal with a medical emergency. The practice had an automated external defibrillator (used to attempt to restart a person's heart in an emergency), emergency medicines and emergency oxygen. Medicines were within their expiry dates and we noted that an allocated nursing staff member undertook regular checks. When we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated), hypoglycaemia (low blood sugar).

Clinical staff had received basic life support training within the last twelve months. However, although non clinical staff had received basic life support training, many staff members had not received refresher training in the last twelve months. We were told that all non clinical staff would receive basic life support refresher training by December 2015.

Plans were in place to respond to emergencies and major situations. The practice had a business continuity plan which described to staff what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure, and contained relevant contact details for staff to refer to (such as support numbers in the event of an electrical power failure). If the practice had to close urgently, there was a reciprocal arrangement in place with a nearby practice which used the same clinical system, therefore minimising disruption. Staff understood their roles and responsibilities regarding business continuity.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The partner GPs and partner nurse practitioner could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with the practice manager and nurse practitioner how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff members' individual computer desktops. Minutes of clinical meetings showed that NICE guidance was routinely discussed including agreement of required actions. Staff demonstrated an understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, the practice was proactive in ensuring that patients with diabetes received regular health checks.

The partner GPs led specialist clinical areas such as diabetes, heart disease and asthma and we noted that the nurse practitioner partner and her nursing team supported this work. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. Our review of the weekly clinical meeting minutes confirmed that this happened.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients including data input, scheduling clinical reviews, managing child protection alerts and medicines management. Information was collated by the practice manager and used to support the practice's clinical audits.

During 2014, the practice undertook two clinical audits. The practice was able to demonstrate how they had used audit results to improve patient outcomes. For example, one audit looked at clinical note taking; so as to better support the sharing of safeguarding information between clinicians and external agencies. We noted that following a clinician training event, the second stage of the audit had highlighted a significant improvement in clinical note taking.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all clinical staff were up to date regarding mandatory training (for example safeguarding (children and vulnerable adults) and basic life support). However, we noted that some non clinical staff had not attended CPR training in the last twelve months. We noted a good skill mix amongst the GPs and also noted a mixture of female and male GPs. One of the practice partners was a nurse prescriber and also led the practice's nursing team. We noted that GPs were up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation within the last 12 months. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had completed annual appraisals within the last 12 months where performance was reviewed and training needs identified. They told us that although formal supervision meetings did not take place, they felt supported in their roles.

Good

Are services effective?

(for example, treatment is effective)

We noted that the practice was shortly planning to merge with another practice. Partners told us that this would enable the new practice to pool clinical best practice and expertise.

Working with colleagues and other services

The practice had systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. For example, regular multi-disciplinary meetings took place with district nurses and health visitors. Clinicians were regularly invited to present at clinical meetings to develop joint working opportunities and we also noted that systems were in place to signpost or refer patients to specialist voluntary sector agencies including domestic violence and carer support services. The practice also organised quarterly nursing home multidisciplinary meetings to support staff in areas such as medicines management and the complexities of advanced dementia care.

Emergency hospital admission rates for the practice were relatively low for long term conditions such as diabetes and lung disease. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for actioning hospital communications was working well in this respect. However, we did not see evidence of a yearly audit of follow-ups to ensure inappropriate follow-ups had been documented and that follow-ups had not been missed.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. When we reviewed the system we saw that patients were referred in a timely manner and that all the information needed for their ongoing care was shared appropriately. We also noted that incoming correspondence was processed in a timely fashion.

Consent to care and treatment

Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Systems were in place for situations where patients lacked the mental capacity; ensuring that 'best interests' decisions were made and recorded in accordance with legislation. We noted that GPs had experience of attending best interest meetings.

We noted that the practice provided adolescent appointments at every session; offered by a partner GP with a special interest in working with adolescents. Staff demonstrated an understanding of Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and staff were clear about when to obtain written consent. However, there was no evidence that the practice routinely audited records to confirm that the consent process for minor surgery had being followed.

Health Promotion & Prevention

The practice worked closely with the CCG to share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area and is used to help focus health promotion activity.

It was practice policy to offer new patients a health check with the health care assistant. We noted that a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Latest available performance data for immunisations at twenty four months and five years was above the average for Havering practices. We also noted that seasonal flu vaccination rates for patients over 65 was slightly better than the Havering practice average; as were dementia diagnoses rates.

Good

Are services effective?

(for example, treatment is effective)

The practice performed better than the England and/or Havering practice average in a number of Quality and Outcomes Framework (QOF) clinical targets for the year ending April 2014. For example, the practice achieved its 90% childhood immunisation target for eligible infants at 24 and 60 months for the "5-in-1" vaccine to boost protection against five childhood diseases including tetanus and whooping cough.

Practice QOF performance on diabetic care was slightly below the Havering practice average regarding percentage of diabetic patients who had had a dietary review in the last twelve months (83.8% compared to 84.4%). However, performance on newly diagnosed diabetic patients who had been referred to an education programme within nine months of diagnosis was slightly better than the Havering practice average (92% compared to 86%).

Practice performance was also better than Havering and England practice averages for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis (73% compared to 62%).

We also noted that at 75%, the practice performed better than the Havering and England practice averages for uptake of seasonal flu vaccine for patients aged 65 and older (respectively 77% and 70%).

Performance on newly diagnosed diabetic patients who had been referred to an education programme within nine months of diagnosis was slightly better than the Havering practice average (92% compared to 86%).

We noted that at 83.8%, practice performance on the percentage of diabetic patients who had had a dietary review in the last twelve months was slightly below the Havering practice average (84.4%). Practice data on women who had had cervical screening within the last five years (77.3%) was slightly below the average for Havering practices (78.4%) and England practices (76.9%).

The reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health.

There were systems in place to follow up non attendees for cervical screening and childhood immunisations. We noted that HIV checks were routinely offered as part of new patient health checks. The practice told us that this because of a reported high local of prevalence.

The practice's performance for cervical screening programme was 77.3%, which was slightly above the national average of 76.9%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Before our inspection, we noted that according to the 2014 national GP patient survey 80% of respondents found receptionists helpful. When we spoke with patients they were positive about how they were treated by reception staff and during our inspection we observed that reception staff treated patients with dignity and respect. When we spoke with a receptionist they stressed the importance of treating patients with respect. Patients spoke positively about how they were treated by GPs and nurses and we noted that this was also consistent with CQC comment card feedback. The practice offered a chaperone service which was publicised in reception. We were told that only nurses performed chaperone duties and that where the offer of a chaperone was taken up, it was noted on the patient's record.

None of the patients we spoke with expressed concern about privacy. They told us that reception staff respected their privacy and confidentiality. We also noted that patient privacy was not highlighted as an area of concern in the 2014 national patient survey or in the Patient Participation Group annual report.

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

Care planning and involvement in decisions about care and treatment

The NHS England 2014 national GP patient survey noted that 94% of respondents felt that the last nurse they saw or spoke to was good at involving them in decisions about their care(above average for Havering practices). Eighty four percent fed back that the last GP they saw was good at involving them in decisions about their care and treatment. We also noted that 97% of respondents said that the last nurse they saw or spoke to was good at listening to them and that 98% felt that nurses gave them enough time.

This was consistent with patient feedback on the day of the inspection. Common themes were that staff explained clearly, showed empathy and that patients had sufficient information to be able to make informed decisions about their care.

The practice website and reception contained a range of information to help patients make informed decisions about their care and treatment (for example managing a long term condition and what to do if a child had a high temperature). A receptionist described the steps that she and colleagues routinely undertook to help patients who needed additional support, understand and be involved in their care.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website advised people how to access local and national support groups and organisations. Survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Face to face and comment card feedback highlighted that staff responded compassionately and provided support when required such as during times of bereavement or prolonged treatment.

The practice signposted patients to organisations providing specialist support such as domestic violence and carers support. End of life care nurses regularly attended multi-disciplinary meetings at the practice. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked.

We noted that 20% of patients had a caring responsibility and we were told that the practice routinely signposted patients to a local carer support network. Information was also provided in the practice reception, on the practice website and in patient participation group leaflets.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, we were told that new patient health checks included an offer of HIV testing, in response to an increased local prevalence.

The practice engaged regularly with Havering Clinical Commissioning Group and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, we noted that the practice would shortly be merging to improve the range and scope of available care.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from its PPG. For example, the 2014 PPG survey highlighted concerns with appointments (telephone access and availability). We were told that a planned merger with another local practice would result in the introduction of Monday to Friday all day opening and the availability of appointments from both sites (we noted that the other practice was located approximately 2.5 miles away and that both sites were on a local bus route). Staff told us that the merged practice would also offer extended hours late opening one evening week. The practice had also developed its social media presence in order to seek patient's views as the merger progressed. Following patient and reception staff feedback, the practice had also recently increased the number of "on the day" appointments to help meet patient needs.

Tackling inequity and promoting equality

We noted that the practice entrance was wheelchair accessible and that the reception/patient waiting area were large enough to accommodate patients with wheelchairs or pushchairs. Clinical rooms also allowed easy access. There was a hearing loop at reception for patients with a hearing impairment and the practice made use of an interpreter service (including British Sign Language interpreters) to ensure patients whose first language was not English could access the service. Toilets were wheelchair accessible and contained baby changing facilities. A wheel chair was kept in reception for patients with impaired mobility.

The reception desk included a lowered section to enable ease of access for wheelchair users and children. We noted that the practice web site was available in local community languages such as Polish and Turkish. There were also translated materials in reception although this did not include the practice complaints policy or new patient information leaflet. We were told that the practice staffing team was multi-cultural and spoke a range of local community languages.

The practice had recognised the needs of different groups in the planning of its services. We were told that for some patient groups the practice prioritised home visits. Where patients did attend the practice, staff told us that they tried to ensure that they were not kept waiting in reception. Longer appointments were offered.

A receptionist outlined the steps that she and reception colleagues routinely undertook to help patients who needed additional support to understand and be involved in their care. The appointments system alerted staff when vulnerable patients contacted the practice so that extended appointments or British Sign Language interpreter could be booked as necessary. The practice also offered "easy read" pictorial leaflets for patients with learning disabilities. We noted that a range of support was offered to carers including signposting to a local carers support network.

The practice offered flexible services and appointments for people with poor mental health including evening appointments (when the practice was less busy) as this was preferred by many patients.

The practice also provided text appointment reminders to all patients which we noted was of particular support to patients with a hearing impairment or who were living with dementia. A screen with the name of the next patient to be seen was located in reception which was responsive to the needs of patients with a hearing impairment.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Although training records showed that staff had not received equalities and diversity training in the last twelve months, staff we spoke with demonstrated an understanding of equality and diversity principles; such as treating patients as individuals.

Access to the service

The practice was open from 8:00am to 6:30pm Monday to Friday (except Wednesday 8:00am to 1pm). The practice was also open every other Saturday. Phone lines were open 8am to 12:30pm and 2pm to 6:30pm with an out of hours service provider offering telephone cover between 12.30pm and 2pm. Information on the out-of-hours service was provided to patients. Appointments were available from 8:00am to 10:300am and 2pm to 4pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the practice website.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. This was also detailed on the website. Patients over 75 had a named GP and home visits were made to those patients who needed one.

The patient survey information we reviewed showed that patient feedback on access to appointments was variable. For example, based on the 128 respondents to the 2014 patient survey, we noted:

- 34% found it easy to get through to the practice by telephone compared to the Havering practice average of 73%.
- 84% were able to get an appointment to see or speak to someone the last time they tried
- 90% said the last appointment they got was convenient
- 63% were satisfied with the practice's opening hours
- 55% described their experience of making an appointment as good

We spoke with three patients during our inspection who all were expressed dissatisfaction with the practice's telephone system. Although routine appointments were available for booking four weeks in advance, patients expressed concern at the lack of "on the day" appointments and at not being able to get through to the practice by telephone. We noted that the practice had sought to improve appointment availability and telephone access. For example, on-line appointments had been introduced to relieve pressure on phones and we were told that a planned April 2015 merger with a local practice would result in the introduction of Monday to Friday all day opening.

The practice's appointments system recognised the needs of different population groups. Home visits and longer appointments were available for older people and people with long-term conditions. Appointments were available outside of school hours for children and young people. Extended opening hours were responsive to the needs of working age people. Appointments for people experiencing poor mental health were offered at less busy times for people who may have found this stressful. We were told that many older patients preferred booking in person and that in response, the practice had increased the availability of routine and daily appointments. We also noted that the practice provided adolescent appointments at every session; offered by a partner GP with a special interest in working with adolescents.

Listening and learning from concerns & complaints

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

We saw that information was available in reception and on the practice website to help patients understand the complaints system. This included advice on how patients could escalate complaints to the Health Service Ombudsman. Patients told us they were aware of the process to follow if they wished to make a complaint but had not needed to make a complaint about the practice.

Records showed that the practice reviewed complaints every month to identify themes or trends which could be used to improve the service. When we looked at the complaints log for March 2014-March 2015 we saw evidence that lessons had been learned from the forty one individual complaints and that improvements had been made to the quality of care as a result. For example, following a complaint received regarding the delayed booking of a patient's first antenatal appointment, the practice had introduced dedicated appointment slots.

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 vision to provide the best possible service for patients within a safe and confidential environment. Staff spoke positively about the innovative nature of the practice; for example highlighting the fact that one of the partners was a nurse practitioner.

We spoke with a range of staff including reception staff, nurse prescriber partner, trainee and partner GPs; all of whom described a patient centred approach. We did not see evidence of a business plan but discussions with staff and review of staff and clinical meeting minutes highlighted that the practice's focus was upon good quality patient centred care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We noted that policy updates were discussed as necessary at weekly clinical meetings. Partners undertook lead roles (for example complaints, management of nursing team and safeguarding). We did not see a record confirming that practice staff had read these policies but staff demonstrated an understanding. For example, reception staff were aware of the procedure and equipment to use in order to safely receive patient samples.

The nurse partner spoke positively about their role and about how it helped ensure that the practice's nursing team were fully involved in governance matters such as the review of policies and procedures.

The practice undertook regular clinical audits in order to improve patient outcomes and we noted that clinical meetings discussed findings. These meetings also included discussion about performance (such as QOF performance) and risk (such as significant events analyses).

The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice. Staff were aware of its location and purpose.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and where action plans had been produced and implemented. The practice monitored risks on a monthly basis to identify any areas that needed addressing and we noted that practice management was split between two posts (covering operations, organisation, IT and finance). This supported a proactive approach to risk identification and management.

Leadership, openness and transparency

There had been very little turnover of staff during the last five years which enabled good continuity of care. Records showed that monthly team meetings took place. Administrative staff told us that there was an open culture at the practice and that they felt comfortable raising issues.

We saw evidence that partner GPs encouraged supportive relationships among staff so that they felt valued and supported. A trainee GP we spoke with was positive about the support provided by partners at the practice. A practice nurse told us that the practice encouraged education and training. Staff participated in social events such as charity runs.

The service was transparent, collaborative and open about performance. Records showed that QOF performance was regularly reviewed and there was evidence that audits were used to improve patient outcomes (for example regarding safeguarding procedures).

However, significant events meetings did not include administrative staff and we noted that some learning and subsequent changes were of particular relevance. For example, following a pregnancy related significant event, ante natal appointments for newly pregnant women were prioritised on the appointments system.

Practice seeks and acts on feedback from users, public and staff

We saw evidence that the practice had acted on patient feedback from surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) including representatives from various population groups such as people with long term conditions, older people and Black and minority ethnic communities. There was evidence that the practice had acted on the group's views but there was no evidence of an action plan with associated timescales.

The practice sought and received staff feedback at monthly team meetings and there was evidence that staff members' views were sought and acted upon. Staff told us they felt supported by the practice partners and involved in decision

Are services well-led?

Good

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

making. For example, following reception staff feedback, the practice had changed the proportion of "on the day" and pre bookable appointments in line with patient demand.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Clinical staff had completed a range of post graduate study in areas such as lung disease and diabetes.

The practice partners spoke positively about their willingness to learn from each other. Complaints were discussed at monthly meetings so as to share learning and improve patient outcomes.

There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice was a teaching practice and we noted that GPs undertook part time undergraduate and post graduate teaching. Staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice.