The Southall Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Southall Medical Centre on 20 January 2015. The practice also provides services at a branch surgery at 70 Norwood Road, Southall. Patients registered with the practice may attend either surgery. On this occasion we inspected the main surgery and overall we rated the service at this location as 'Good'.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. The practice was also providing good care for older people; families, children and young people; people of working age; people whose circumstances may make them vulnerable; and, people experiencing poor mental health. The practice required improvement for providing safe services and people with long-term conditions.

Our key findings were as follows:

- The practice had effective systems in place to manage risks associated with staff recruitment, infection control, child protection and medical emergencies.
- The practice understood the needs of the population and had developed the service and skills of the staff team to meet patients' needs. We found that care for long-term conditions such as diabetes was being managed effectively in the community and care was provided in partnership with other specialist and community services.
- Patient satisfaction scores were in line with local averages for being treated with dignity, respect and the kindness of staff. Twenty-five patients completed Care Quality Commission (CQC) comment cards about the service before our inspection. All of these were positive about the service and staff.
- Feedback was more mixed about access to appointments and several patients we spoke with reported difficulty getting through to the practice by telephone. The practice was aware of the issue and had increased the number of staff answering the telephones at busy times.

Summary of findings

- We found that staff were well supported. Staff told us the practice was clinically and managerially well-led with opportunities to reflect on practice and improve.

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

Importantly, the provider must:

- Ensure that a senior member of the clinical team has effective oversight of patient reviews and health checks. These were being both carried out and signed off by the healthcare assistant.

In addition the provider should:

- Have an automated external defibrillator on the premises for use in an emergency or carry out a risk assessment showing why this equipment is unnecessary in this practice.
- Review the content of the locum pack to ensure that any locum doctor unfamiliar with the practice has access to key information about practice policy and procedure
- Continue to monitor telephone access to the practice at peak times of day

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. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Reviews and investigations were carried out promptly and lessons learned were shared. The practice had systems and processes to assess and manage risks, for example, in relation to repeat prescribing, infection control and the safety and security of the premises and equipment.

The practice carried out necessary checks when recruiting new members of staff to ensure they were suitable to work in general practice. Staff members were trained or in the process of completing training to the appropriate level on child protection. Staff who undertook chaperone duties were clear about how to carry out this role effectively.

However, we found that senior clinical staff did not provide effective oversight of routine for patients with long term health conditions. We found one case where issues with a patient's medicines should have been followed-up following their annual review but had been missed.

The practice had a range of equipment and medicines on the premises for use in an emergency and staff were trained how to respond in an emergency. However, the practice did not have an automated external defibrillator on the premises, potentially limiting the effectiveness of their response if resuscitation was required.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute For Health And Care Excellence (NICE) and used it routinely, for example following guidelines to discontinue prescribing certain medicines. People's needs were assessed and care was planned and delivered in line with current legislation.

The practice did not have a planned annual audit programme but had completed clinical audit cycles and could demonstrate improved practice and outcomes for patients as a result. Staff were suitably qualified to deliver effective care and treatment and the practice worked with other health care professionals to deliver effective care to those patients with more complex needs.

Verbal or written consent was sought from patients before examination or treatment. Staff were aware of their responsibilities

Summary of findings

in relation to key legislation such as the Mental Capacity Act 2005. We saw evidence that the doctors assessed patients' capacity to make key decisions when appropriate and recorded the outcome of any assessment.

The practice provided a range of health promotion services and had performed well in relation to uptake rates for childhood immunisations and cervical screening.

The practice team monitored its performance in relation to other practices in the area and was scoring highly on the Quality and Outcomes Framework (QOF).

Are services caring?

Good

The practice is rated as good for providing caring services. Data from national and local patient surveys showed that patients rated the practice highly for the quality and compassion of its care. Patients who commented before or during the inspection said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that staff greeted patients with kindness and respect, and maintained confidentiality.

Information to help patients understand the services available was easy to understand and presented in a range of languages.

Patients were informed about culturally specific counselling services in the area. Patients experiencing bereavement were referred to specialist support services.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population to secure service improvements where these had been identified. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback.

The practice provided information for patients on how to access primary care services when the practice was closed in its practice leaflet and via a recorded message on its telephone line. However the practice website included out-of-date information about this.

Patient feedback on access to the service was more mixed with some patients telling us they had great difficulty in getting through to the practice early in the morning by telephone. The practice was aware of the issue and had recently dedicated a member of the administrative team solely to answering the telephone at busy times of the day.

Summary of findings

Information about how to complain was available and the practice responded promptly when issues were raised. Learning from complaints and feedback was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Governance arrangements were in place including policies and procedures to govern activity. Policies and procedures were discussed at practice meetings to embed learning with staff.

The practice did not have a formal vision and strategy in place, although staff we spoke with told us that the practice aims included providing an effective service to patients and being a friendly, approachable team and this was also articulated on the practice website.

There was clear leadership and accountability and staff understood their level of responsibility. Regular meetings were held, staff were supported with training and their performance was monitored through annual appraisals.

The practice obtained feedback from staff and patients, for example through monthly staff meetings and meetings of the Patient Participation Group. The practice acted on feedback to improve services.

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. Patients over the age of 75 years of age were provided with a named GP and care plans were developed for these patients. Care and treatment was planned with regular reviews to meet the needs of frailer patients.

There were risk assessment processes in place to identify patients at risk of unplanned hospital admission. These patients were reviewed on a regular basis and care plans developed for them. Home visits were provided for patients who were housebound.

The practice did not have any patients receiving palliative care at the time of the inspection. The staff had processes in place to work with other specialists to provide effective end-of-life care based on the “Gold Standards Framework” approach.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

The practice provided specific clinics for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). The practice coordinated diabetes care with community and specialist services for example, a community foot clinic. We spoke with two patients with long-term conditions who felt their condition was monitored effectively and their health had benefited as a result of the care they received from their GP and the practice nurse.

Patients with a range of long-term conditions were offered annual reviews to check that their health and medication needs were being met and in line with current guidance. There was a recall system in place to provide preventative and continuing care for patients. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

However, we found that the health care assistant given responsibility for signing off annual patient reviews, for example for patients with diabetes. This did not allow for sufficient oversight from a qualified medical professional.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. We spoke with a number of parents on the day of the visit. They told us they were very happy with the care their children had received. Parents told us that in their experience, the doctors communicated well with younger children and were able to put them at ease.

There were systems in place to identify and follow-up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances or who repeatedly did not attend for appointments.

Staff were trained in child protection and were aware of the procedures to follow if they were concerned about a child's wellbeing. Multidisciplinary team meetings were held with GPs, health visitors, social workers and children's centre staff to discuss and monitor vulnerable children under the age of five. The practice provided a range of services for families, babies, children and young people including child development checks and immunisations.

The practice used a messaging service which reminded parents when their child's immunisations were due and follow-up telephone calls were made if appointments had not been made. Practice appointments were available outside of school hours and the premises were suitable for children and babies, for example baby-changing facilities were available.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age people. The practice had a higher than average proportion of working age adults on its list.

The practice operated limited extended hours with the healthcare assistant available on Saturday mornings for health checks, reviews and advice. The practice was not open outside 8:00am to 6:30pm during the week. However 82% of respondents to the National GP Patient Survey reported their last appointment was convenient.

Telephone consultations were available on request during opening hours and the practice was in the process of introducing online appointment booking. The practice had also introduced a messaging service which automatically sent text message reminders to patients. One patient we spoke with had signed up to this service and said they found it useful.

The practice offered health checks for new patients and patients aged 40-74. The practice had completed over sixty health checks in the previous three months.

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 had a register of patients with learning disabilities and offered annual health checks and longer appointments to this group. Almost all patients on the register had had a health check in the previous 12 months.

An interpreter service was available for patients whose first language was not English. The practice website provided information to explain the role of UK health services, the National Health Service (NHS) and the role of GPs for asylum seekers in 20 languages. The practice did not have any homeless patients on its list but we were consistently told by staff that homeless patients would be able to register.

Staff knew how to recognise signs of abuse in vulnerable adults and children. One of the GPs was the assigned lead for safeguarding and child protection. Staff were aware of their responsibilities to share information, report safeguarding concerns and knew how to contact relevant agencies in normal working hours and out-of-hours. The practice had identified domestic violence and female genital mutilation as relevant issues and staff had attended training on recognising warning signs and what to do if they had concerns.

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. Practice recall systems were in place for mental health reviews and physical health checks for patients with enduring mental health problems. The practice worked with other health and social care professionals to ensure a multi-disciplinary approach for care management of people experiencing poor mental health.

The practice was signed up to the dementia direct enhanced service (DES) to provide an annual health check for people with dementia. The practice developed care plans for this group and patients were provided with a named GP.

Staff had received training in dementia care, the Mental Capacity Act 2005 and undertaking capacity assessments. We saw evidence that doctors had assessed patients' capacity to make specific decisions when there was uncertainty about their mental capacity.

Summary of findings

What people who use the service say

The 2014 National GP Patient Survey results covered both the main and branch surgeries. The response rate for this practice was 17% which was very low. The results suggested that patients were generally positive about the quality of care they received from their GP with 80% reporting the GP was good at listening to them and almost all respondents reporting they had confidence in the practice nurse. These results were in line with average scores for practices in the NHS Ealing Clinical Commissioning Group (CCG) area. However, the practice scored relatively poorly in relation to ease of obtaining an appointment and only around half of patients responding to the survey said they would recommend the practice to others.

The practice had carried out its own patient survey in 2014 across both the main and branch surgeries using a commercially available, validated survey questionnaire for use in general practice. The findings from this survey of 100 patients were positive across all aspects of care assessed including ease of making an appointment. Over 80% of respondents to this survey said they would recommend the practice.

We spoke with 12 patients who used the service and received 25 Care Quality Commission (CQC) comment cards with feedback from patients. The feedback from the comment cards was wholly positive about the practice with patients saying that the staff were caring, understanding and involved patients in treatment choices. However, seven of the 12 patients we spoke with said they had found making an appointment difficult. In particular it was difficult to get through to the practice by telephone in the morning. One patient told us it had taken them over an hour to get through in the early morning.

The practice also engaged with patients through a practice patient participation group (PPG). We spoke with a member of the PPG who told us that the practice was responsive to patient feedback about the service.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must:

- Ensure that a senior member of the clinical team has effective oversight of patient reviews and health checks. Ensure that a senior member of the clinical team has effective oversight of patient reviews and health checks. These were being both carried out and signed off by the healthcare assistant.

Action the service SHOULD take to improve

The provider should:

- Have an automated external defibrillator on the premises for use in an emergency or carry out a risk assessment showing why this equipment is unnecessary in this practice.
- Review the content of the locum pack to ensure that any locum doctor unfamiliar with the practice has access to key information about practice policy and procedure
- Continue to monitor telephone access to the practice at peak times of day

The Southall Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector**.** The team included a GP, and a practice manager.

Background to The Southall Medical Centre

The Southall Medical Centre is located in the borough of Ealing. The practice provides NHS primary medical services through a General Medical Services contract to around 7,200 patients in the local community. The practice has two surgeries with the main surgery located at Lady Margaret Road and a smaller branch surgery about two miles away, also in Southall. Patients registered with the practice are able to attend either surgery. This inspection focused on the service provided at the main surgery. The practice told us that around 4300 patients primarily used the main surgery.

The practice has larger than average proportions of adults in the 25-39 age range and babies on its patient list. The practice is ethnically diverse with many patients speaking English as a second language. Income deprivation levels for the practice population are also higher than the English average. The prevalence of diabetes is particularly high locally.

The current practice staff team comprises two GP partners (who own the practice), a salaried GP, a practice nurse, healthcare assistant, a practice manager and a small team of reception and administrative staff. There are two female doctors and one male doctor.

Opening hours are between 8.00am -1.00pm and 2:00pm - 6.30pm during the week with the exception of Thursday afternoon when the main surgery is closed. Telephone consultations with a GP are available during normal opening hours. The health care assistant also offers appointments on Saturday mornings for example, for annual health checks and annual reviews with patients with long-term conditions. The practice undertakes home visits for patients who are housebound or are too ill to visit the practice.

The practice has opted out of providing out-of-hours services to their own patients and refers patients to the '111' service for healthcare advice. Patients ringing the practice out of hours are provided with instructions on how to access urgent primary medical care and emergency health services. The practice also participates in a network of local practices which in turn offer a walk-in service on Saturday mornings for patients with urgent problems. On this basis, the practice staff provide the urgent Saturday walk-in service for patients from any of the practices in the network on six weekends a year.

The practice is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures; maternity and midwifery services; surgical procedures and treatment of disease, disorder and injury.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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. These 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 including the National GP Patient Survey 2014. We asked other organisations such as NHS England and NHS Ealing Clinical Commissioning Group (CCG) to share what they knew about the service. The practice sent us a summary of information about their clinical audit, significant events and complaints.

We carried out an announced visit on 20 January 2015. During our visit we spoke with a range of staff including GPs, the practice manager, the practice nurse and reception staff. We reviewed a range of documentary information such as practice policies, additional audit reports and training records. We also reviewed a number of individual patient care plans and medication reviews. We spoke with 12 patients who used the service and one member of the practice Patient Participation Group. We reviewed comment cards completed by 25 patients sharing their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts. The practice had a register covering both the main and branch surgeries of significant event reports over the previous decade. The staff we spoke with were aware of their responsibility to raise concerns, and knew how to report incidents and near misses. They knew how to access the significant events register.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events and incidents were reported on a standardised form which included details of the event, key risks, specific action required to prevent reoccurrence and learning outcomes. All staff including the administrative team were aware of the process to follow and sent completed incident forms to the practice manager. Staff we spoke with were able to provide examples of recent incidents they had discussed as a team.

Significant events were a standing agenda item at the monthly practice meetings. The most significant event had involved a patient becoming unwell and collapsing in the waiting room. The incident had been documented and discussed within the practice. Staff had responded appropriately and had called the emergency medical services. The significant incident review had additionally identified learning for both clinical and non-clinical staff around using the panic button function and managing the expectations of other patients during a medical emergency.

The doctors were signed up to receive automatic national patient safety alerts about medicines and products and the practice manager emailed relevant staff with all other alerts that came to the practice centrally as appropriate. Staff we spoke with were able to give examples of recent alerts and we saw these had been actioned. For example, one of the GPs showed us evidence they had reviewed the treatment of patients taking Ivabradine, a medicine to treat the symptoms of angina, in line with guidance in a recent national safety alert. The manager did not however have a system for monitoring that safety alerts had been implemented.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults which were in line and referenced the local CCG procedure and contacts. There were safeguarding policies in place for both children and vulnerable adults which included contact details for the local safeguarding and social care teams including the duty and out-of-hours teams. The practice displayed flowchart information in the consultation rooms and reception office detailing the procedure and contact telephone numbers to report concerns about abuse of children, vulnerable adults and domestic violence.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. All staff we spoke with knew who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. Staff we spoke with during the inspection were able to describe signs of abuse in older people, vulnerable adults and children. The practice maintained a register of children who were vulnerable and at risk. There was an alert message system to highlight vulnerable patients on the practice's electronic records.

We reviewed training records which showed that all staff had received or were in the process of receiving relevant role specific training on child protection. The qualified GPs had been trained to Level 3. The nurse had completed Level 2 training with other staff members trained to Level 1 or 2. The practice was aware that the healthcare assistant had not yet completed Level 2 training although they were required to complete this as a clinical member of staff. They told us they were in the process of arranging for this training to be completed. Staff had received training on recognising abuse in vulnerable adults. The reception staff had also received additional training on domestic violence and recognising non-verbal cues that might indicate abuse.

The doctors had identified a gap in their knowledge around female genital mutilation. As a result they had attended training offered by the local Clinical Commissioning Group (CCG) ahead of the summer months when girls were particularly at risk.

The practice had a chaperone policy and signs were visible in the waiting area and in the consultation rooms offering a chaperone service. The chaperone policy contained guidelines on who could act as a chaperone, the role of the

chaperone and confidentiality requirements. Practice policy was that chaperoning should, wherever possible, be carried out by clinical staff familiar with the procedural aspects of personal examination. Two of the receptionists had undertaken formal chaperone training and occasionally undertook chaperone duties if clinical members of staff were unavailable.

Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. All staff providing chaperone duties had undergone a criminal records check. Clinical staff had an enhanced criminal records check while administrative staff had a standard check. The standard check does not include a check of whether individuals are on barred lists for working with children or vulnerable adults.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice followed written procedures to ensure that medicines were kept at the required temperatures. These described the action to take in the event of a potential failure. The fridge temperature was checked and documented twice a day. Records showed that the appropriate temperature range had been maintained. The practice was in the process of introducing a new fridge temperature recording sheet which included recording of maximum and minimum daily temperatures in line with good practice guidance.

Processes were in place to check that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and stored securely. The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance.

The practice had a repeat prescribing policy which had been reviewed and updated in October 2014 by one of the GPs. Their recommended changes were discussed at a practice meeting. These included more systematic use of medication review with the aims of checking that patients were taking medicines without side effects; understanding the reasons for any non-compliance; to synchronise individual prescriptions were appropriate and to link blood and urine test requests with repeat prescriptions for patients with relevant long-term conditions.

The GPs met every other month with the local NHS prescribing advisor. We saw records of these meetings which showed, for example, that the practice had carried out case reviews of all older patients with ten or more items on repeat prescription. They had also reviewed the prescribing of medicines which were no longer recommended for NHS prescription, such as Omacor, a dietary supplement. The practice had documented these reviews, action taken and had identified learning points for future prescribing practice.

The health care assistant carried out routine annual reviews for patients with long-term conditions. We found insufficient GP supervision, monitoring and follow-up of these reviews particularly around patients' medicines. We looked at a number of recently completed reviews and found one case where the patient was not taking their medicines as prescribed. Thus should have triggered further follow-up by the patient's GP but had been missed.

Cleanliness and infection control

The premises were clean and tidy. Patients told us they had no concerns about cleanliness or infection control. The practice contracted with a cleaning company with set cleaning schedules and records of monthly, weekly and daily tasks. Cleaning was carried out in line with current national guidance, for example in relation to cleaning materials and equipment.

One of the GP partners was the lead for infection control for the practice and had undertaken online infection control training. Staff received induction training about infection control specific to their role and also completed online infection control training.

The practice had an infection control policy. This was comprehensive and covered for example, the disposal of sharps and the management of instruments, biological substances, waste management and hand washing. There was also a protocol for needle stick injury. The practice used single-use equipment wherever appropriate.

Are services safe?

Personal protective equipment including disposable gloves was available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in treatment rooms and the staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were also provided in the treatment rooms. The treatment room used for minor surgery was appropriately equipped with a designated clean area.

A risk assessment for Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) had been carried out in July 2013 with no risks identified.

The practice had been audited by NHS England the week before our inspection. The practice was generally complying with good practice guidelines on infection control. The audit had resulted in a number of recommendations and the practice had agreed to implement these, for example, to consistently carry out water temperature checks in line with the Legionella risk assessment and to ensure that non-vinyl gloves were available in every treatment room.

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 equipment was tested and maintained regularly in line with the manufacturers' instructions and we saw equipment maintenance logs and other records confirming this.

We saw documentary evidence that relevant equipment such as spirometers and blood pressure monitors were calibrated annually (that is, checked to ensure that they gave readings that were accurate and reliable). The practice had a contract with an external agency to provide portable appliance testing (PAT) and calibration of equipment annually. The practice kept records to show that the electrical installation and gas safety were inspected as required and found to be satisfactory. The practice lift was maintained and serviced regularly by a specialist contractor.

Staffing and recruitment

During our inspection we reviewed a number of staff files. The staff files we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, right to work checks, references, qualifications, registration with the appropriate professional body and employment history. We noted that enhanced criminal records checks through the Disclosure and Barring Service (DBS) had been undertaken for all clinical staff and standard criminal records checks for non-clinical staff who provided chaperoning services. The practice did not obtain DBS checks for other non-clinical staff.

Two members of staff had been recruited within the last twelve months. Their recruitment files were complete with evidence of completion of induction and other mandatory training.

The practice provided a comprehensive induction for staff as part of the recruitment process. We saw induction programmes for clinical and administrative staff. However, the locum pack was more limited with little current information for temporary staff on referral routes, safeguarding, significant event procedures and repeat prescribing. We were told that the practice regularly hired a specific locum doctor who worked half-time at the practice and was familiar with its policies and procedures. However, the practice acknowledged that there were likely to be times when it hired temporary staff at short notice who were unfamiliar with the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There was a rota system in place for the different staffing groups to ensure that enough staff were on duty and there was an appropriate skill mix to facilitate the clinics being provided.

The practice opened on Saturday morning for appointments with the healthcare assistant who conducted health checks and routine annual reviews with patients with long-term conditions. This session was classed as "extended hours opening" by the practice. We reviewed the Saturday session and saw that appointments with the healthcare assistant were generally well-filled. We were told that a GP was always onsite at this time to ensure safety but did not provide any clinical sessions. We found little evidence of active clinical supervision or monitoring of the reviews carried out by the healthcare assistant.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

to the practice. The practice also had a health and safety policy and we saw evidence of health and safety training as part of staff induction. One of the GP partners was the nominated health and safety representative.

The practice carried out annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety lead and policy. Health and safety information was displayed and visible to staff.

We saw evidence of health and safety risk assessments where identified risks were logged in a risk assessment table. For example, cleaning spillage of body fluids was identified as a hazard to staff. The control measures to mitigate this risk included the use of hypochlorite granules and spillage kits had been placed in the consulting rooms.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and interviews showed that all staff had received training in basic life support within the last two years and knew how to respond to an emergency. Emergency equipment was available including access to oxygen and emergency medicines. When we asked members of staff, they knew the location of this equipment and records confirmed that it was checked regularly. However, the practice did not have an automated external defibrillator on the premises (used to attempt to restart a person's heart in an emergency) and had not conducted any risk assessment to support this decision.

The practice kept a small stock of medicines for use in an emergency. These included medicines for the treatment of cardiac emergencies, asthma attack and anaphylaxis. Anaphylactic kits containing adrenalin were available in the consulting rooms and flowchart posters were displayed with the procedure to follow in the event of a patient experiencing anaphylactic shock. All the medicines we checked were in date and the practice kept records showing the emergency medicines were regularly checked and new stock ordered before expiry.

A business continuity plan was in place to deal with a range of emergencies that might affect the daily operation of the practice. Emergencies identified within the plan included loss of access to the building, computer systems, paper medical records, telephone systems, electricity and water supplies and staffing issues. The business continuity plan contained a comprehensive list of contact details for staff to refer to, for example electricity and gas suppliers. The practice was potentially able to temporarily run solely from the main or branch surgery if an emergency affected one site.

The practice had carried out a fire risk assessment. Records showed that staff were up to date with fire training, the fire alarm was tested weekly and staff practiced evacuation simulations every six months.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and referred to locally agreed care pathways for specific conditions. NICE guidelines were discussed in the monthly clinical meetings and prescribing review meetings every two months. We reviewed a number of care plans and saw that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. The practice used a local referral management service which reviewed their referrals and fed back to the practice on any inappropriate referrals. The GPs told us they had found this a helpful source of learning.

Individual GPs were allocated to lead specialist areas such as learning disabilities and mental health. The practice nurse and health care assistant ran clinics for specific conditions such as asthma, chronic obstructive pulmonary disorder and diabetes. Annual reviews were offered to patients with long-term conditions in line with best practice guidance. Two patients we spoke with who had a long-term condition both confirmed they had received regular monitoring and checks and said this had benefited their health.

The practice had also recently completed a review of the disease registers to ensure that the number of patients registered with the practice with long-term conditions such as diabetes and coronary heart disease was accurate. As a result, for example, patients' contact details had been updated.

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 need and that age, sex and race was not taken into account in this decision-making. Patients we spoke to told us that they felt listened to in decision-making about their care. The care planning process included consideration of patient and carers' views about their care and their goals for treatment.

Management, monitoring and improving outcomes for people

The practice had achieved 96% in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014. The QOF is a system to remunerate general practices for providing good quality care to their patients.

The practice showed us examples of clinical audits that had been undertaken over the last year. These included cancer referral; inadequate smears; minor surgery; infection control and Vitamin B12 prescribing. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). We saw evidence that the practice audited aspects of prescribing in the minutes of the bi-monthly prescribing meeting.

We saw an example of an audit the practice undertook into its prescribing of pioglitazone, a medicine used to treat the symptoms of diabetes, in October 2013. The aim was to ensure that prescribing was in line with good practice as this medicine is not recommended for certain patients. The audit identified 24 practice patients who were prescribed pioglitazone and the doctors assessed each patient's risk of adverse complications. Each patient was also invited to discuss their medicines with their doctor. As a result most patients decided to change their prescription to an alternative medicine or treatment strategy. The practice discussed the results of the audit and good practice in relation to prescribing for diabetes at the clinical team meeting. The practice subsequently re-audited its prescribing of pioglitazone in October 2014 and found that only one patient was now taking this medicine and this had been reviewed with them.

The practice used a risk stratification tool to identify patients at risk of unplanned admissions to hospital and develop care plans for these patients. We saw a number of examples which included information for patients and carers about early warning signs and how to respond. This group of patients were also prioritised for same day appointments by the reception team.

The practice offered patients with learning disabilities an annual health check and developed care plans for patients who would benefit which included information about their goals for care

The practice did not have many patients (one percent) who were receiving palliative care at the time of the inspection.

Good

Are services effective?

(for example, treatment is effective)

We were told that when a patient was identified as coming to the end of their life, the practice used a template based on the 'Gold Standards Framework'. This is a recognised model of care to **help** doctors, nurses and care assistants provide the high quality care in line with the patient's wishes. The practice kept a palliative care register, provided patients with a named GP and liaised with palliative care nurses to discuss the care and support needs of these patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support and infection control.

The GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England). All staff completed an induction programme when they started working for the practice.

Staff received annual appraisals that identified personal development and learning needs. We saw appraisal documentation for members of staff which identified clear areas for development and timescales for achieving these.

Staff confirmed that the practice provided training and funding for relevant courses. For example, the health care assistant was currently studying for a Level 2 smoking cessation qualification to be able to provide a smoking cessation service to patients in-house. One of the receptionists had recently started at the practice and was aware of opportunities to develop their role within the primary care team.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. The GPs attended multidisciplinary group meetings every two months to discuss the needs of complex patients, for example patients experiencing poor mental health. The multidisciplinary group meeting was attended by consultants for the care of the elderly, diabetic consultants, mental health workers, community matrons, social worker, community psychiatric nurse, diabetic nurses and community pharmacists. Staff felt these meetings worked well and were a useful forum for sharing important information.

The practice met with the local NHS prescribing advisor every other month to review practice prescribing in relation to complex cases or in the light of current prescribing guidelines and good practice.

The practice liaised with the local Intermediate Care response team who provided rapid assessment for patients in their home following a referral. The team developed a multi-disciplinary plan of care for the next three to seven days with the input of the GP, supporting the patient at home to avoid admission to hospital or A&E.

Information sharing

Patients were able to make bookings for planned hospital care through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system worked well.

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

Hospital patient discharge letters were scanned into the practice electronic system and assigned to the GPs. We saw that the flow of information, including letters and test results was well managed within the practice with incoming information transferred to the appropriate clinician the same day. The practice had a "duty doctor" system to ensure that incoming information was reviewed by a doctor if the normal GP was away.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in relation to this legislation. We saw documented mental capacity assessment, for example, in relation to a medication review with an older patient. This patient was

Good

Are services effective?

(for example, treatment is effective)

assessed as having the capacity to understand the implications of changing or stopping certain medicines and so the doctor was able to proceed with the review as planned.

GPs understood the guidelines (Gillick competency) to decide whether a child is able to consent to their own medical treatment without the need for parental permission or knowledge.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of any health concerns detected and these were followed-up in a timely manner. The practice also offered health checks for patients aged 40 -75.

The practice performance for cervical screening uptake was 81% which met the local CCG target of 80%. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was performing well for childhood immunisations in comparison to the local CCG average with 90% achievement of target for two year old children and 89% for five year olds.

The health care assistant provided a range of health promotion and prevention services including blood pressure monitoring, smoking cessation referrals and healthy lifestyle advice.

Health information was displayed in the patient waiting room on a television screen and there were a range of posters and leaflets on display. The practice website provided health information for patients including family health, long term conditions and minor illnesses. Videos were also provided on the website for patients and signposting to organisations such as Diabetes UK.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed data from the 2014 National GP Patient Survey (77 responses), the practice's 2014 patient survey (100 responses), and 25 comment cards that patients completed in advance of the inspection. We also spoke with 12 patients on the day of the inspection.

The evidence from these sources showed patients were satisfied with how they were treated. The results of the National GP Patient Survey showed that the practice was performing in line with the CCG and England averages for its satisfaction scores on consultations with 80% reporting the GP was good at listening to them and over 90% of respondents reporting they had confidence in the practice nurse and their doctor. The results from the practice's own satisfaction survey also showed that patients were positive about the quality of care they received from doctors, nurses, health care assistants and the reception team.

Twenty-five patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. These were all positive about the quality of the service. Patients described the service as excellent and the staff as helpful, understanding and friendly. Patients we spoke with told us they were happy with the care provided by the practice and said their dignity and privacy were respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that personal information was kept private. The practice waiting area was large which allowed the seating to be located some way from the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and generally rated the practice well in these areas. Eighty-six percent said their GP was good at listening to them compared to the local clinical commissioning group (CCG) practice average of 83%. Seventy-nine percent said they had enough time with the doctor which was the same as the local CCG practice average.

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.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with and the feedback forms we received described the staff as understanding and compassionate. Notices in the patient waiting room, and a television information screen provided information about accessing emotional support. The patient website informed patients how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, they were contacted and referred to counselling and bereavement services if they wished.

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 senior practice team understood the broader commissioning priorities for the borough and the socio-demographic profile of the population. The GP partners engaged with other GP practices, local commissioners and other organisations to provide and maintain a service that met patients' needs.

There was a high prevalence of diabetes in the local population. The practice ran diabetes clinics which were run by the lead GP and the practice nurse. The clinics provided information for patients on how to manage their own care effectively. The practice website also provided patients with comprehensive information about diabetes which included videos produced by Diabetes UK. The practice was achieving well on the QOF indicators related to management and control of diabetes.

The practice served a young population group. To meet the needs of the working age and student population, the practice provided text message appointment reminders. However, the practice did not offer extended hours for appointments during the week in the evenings. The practice was open on a Saturday morning for patients to access healthcare assistant appointments. The practice also provided a weekend emergency walk-in service in collaboration with other local practices.

Tackling inequality and promoting equality

Many patients using the practice spoke English as a second language. The practice team were between them able to communicate in a number of languages including Punjabi, Italian, Arabic and Somali.

The practice also offered the use of a telephone translation service. The practice website provided fact sheets which gave information to explain the role of UK health services, the National Health Service (NHS) and the role of GPs to patients who were newly-arrived to the UK. These were available in 20 different languages. The content and style of these fact sheets had been tested with user groups to ensure that the information was clear.

The practice had an equality and diversity policy in place and provided staff training on equality through e-learning. Staff we spoke with confirmed that they had completed the training in the last 12 months and were able to describe various forms of discrimination. We saw evidence of equality and diversity being discussed in practice meeting minutes.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was accessible to people with mobility difficulties and the first floor was accessible by lift. The reception area was equipped with a hearing induction loop. We saw that the waiting area was large enough to accommodate patients with wheelchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice opening hours were between 8.00am - 12:00am and 2:00pm - 6.30pm during the week and Saturday 9.30am - 12:45pm. The practice was closed on Thursday afternoons. Saturday appointments were available with the health care assistant. The practice provided information for patients by answerphone, on their website and in the practice leaflet about how to access alternative primary and urgent care services when the practice was closed and over the lunchtime period.

Telephone access was available during core hours and home visits were provided for patients who were housebound or too ill to visit the practice. Patients could book appointments by telephone and in person. The practice was in the process of making online booking available. Appointments were generally ten minutes in length however longer appointments were also available for people who needed them. For example, patients with learning disabilities were offered double appointments and patients on the integrated care programme were prioritised for appointments.

Telephone access was available during practice opening hours. The appointment system had availability for urgent appointments each day. We spoke with several patients who were attending for an urgent appointment the same day and they said this process had been straightforward.

There was mixed feedback from patients about ease of accessing the service more generally however. The practice scored poorly on access in the National GP Patient Survey and only around half of patients would recommend the practice to others. The practice's own patient survey in 2014 however found that patients were satisfied with

Good

Are services responsive to people's needs?

(for example, to feedback?)

access and 80% would recommend the service. All the comment cards we received were positive with no concerns raised about access, but seven out of the 12 patients we spoke with had experienced difficulty getting through to the practice on the telephone to make an appointment. One person said they had tried for an hour. The Patient Participation Group had also raised this as an issue. In response, the practice had recently assigned an administrator to focus solely on answering the telephone at busy times of the day and had installed a second phone line. It was too soon to assess if these measure were addressing the problem.

Information was available to patients about appointments on the practice website and there was also information for patients on how to access urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave information on how to access urgent care out-of-hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who managed all non-clinical complaints and the on call duty doctor managed the clinical complaints in the practice.

We saw that the complaints procedure was displayed on posters in the reception area and there was a complaints leaflet which patients could take away. There was also information about making a complaint on the website.

We looked at the complaints log for the last 12 months which recorded complaints received verbally and in writing. We reviewed three complaints and found that these had been managed in an appropriate and timely manner. In response to complaints regarding reception staff, the practice had arranged in-house training for staff with the practice manager on taking messages and escalation to the duty doctor.

The practice reviewed complaints annually to detect themes or trends. We looked at the complaint summary report for the last year and themes identified included recording of messages, communication skills and the processing of prescription requests. Lessons learned and actions taken in response to the complaints received were documented and we saw practice meeting minutes to evidence complaints being discussed and shared with staff.

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 did not have a formal vision and strategy in place. However, staff we spoke to told us that the practice aims included providing an effective service to patients and being a friendly, approachable team. The practice articulated its aim to provide an effective service on its website. The GP partners told us a longer-term goal was to become a GP training practice but they did not yet have plans in place for achieving 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 shared drive of any computer within the practice. The practice had a proactive approach to embedding policy into the day to day practice operations. Each month a staff member was nominated to choose a policy and provide a presentation based on this policy for their colleagues at the practice meeting.

The practice had assigned lead roles to the GPs for particular areas such as safeguarding, child protection and infection control. Staff told us there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The overall QOF score for this practice for 2013/14 showed it had performed 1.7 % above the CCG average and 1.8 % above the England average. QOF data was regularly discussed each week to monitor progress with targets.

The practice used clinical audit to monitor quality and systems to identify where action should be taken.

Leadership, openness and transparency

The practice held regular meetings for practice staff. Whole practice team meetings were held monthly, clinical meetings were held monthly and multidisciplinary meetings were attended by clinical staff every two months. Notes were kept of meetings and these were stored on the computer shared drive.

We spoke with two GPs, the practice manager and two receptionists, one of whom was new to the practice. They were all clear about their own roles and responsibilities.

They told us that they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

We reviewed a number of policies and procedures, for example recruitment and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice also had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff were aware of the whistleblowing policy if they wished to raise any concerns and were able to describe circumstances in which they would use it.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the Friends and Family Test (a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) suggestions, and complaints received. The practice had an online comments and suggestions form on the practice website which asked patients for their feedback about the practice.

We looked at the results of the national patient survey and 82% of patients said that the last appointment they had was convenient however only 34% found it easy to get through to the practice by phone which was below the local CCG average of 70%. As a result of this feedback, the practice added an extra telephone line and had arranged the staff rota to ensure that there were always two members of the reception team on shift to cope with busy periods. The practice was also in the process of introducing an online appointment booking service in response to feedback from patients to improve access to appointments.

Staff and members of the PPG we spoke to provided examples of other improvements that had been made to the practice as a result of patient feedback . This included the installation of a television screen within the waiting area to advertise information about the practice and provide health promotion advice.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) of approximately 12-15 members including members from various ethnic and cultural backgrounds and of various ages. The PPG met every quarter and was attended by a GP and some practice staff.

The practice had gathered feedback from staff through practice meetings and appraisals. Staff told us their managers were approachable and they felt comfortable to give feedback and discuss any concerns or issues. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff received an annual appraisal which identified areas for development with timescales for achieving these. Staff we spoke to told us that their appraisals were effective in monitoring their development.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients. For example, an incident occurred when a patient entered the surgery when the practice was officially closed and no staff were present in reception. As a result, the practice had subsequently implemented a system whereby the last member staff to leave was always responsible for checking that the door was locked. The incident was discussed during at a practice meeting and recorded to ensure the learning was shared.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the provider was not ensuring that care and treatment was always provided in a safe way. In particular, the provider was not ensuring that a person who was appropriately qualified, competent and skilled had sufficient oversight of clinical reviews of patient care.This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which in this respect, corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12(1)(2)(a)(c)(g)