Parkway Health Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the AT Medics GP practice at Parkway Health Centre on 13 May 2015. Overall the practice is rated as good.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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
- 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 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.

We saw a number of areas of outstanding practice:

- There were excellent examples of how the practice's vision and ethos was implemented by the staff team working together to maintain high standards, deliver positive health outcomes for patients and foster a supportive work environment. The practice had achieved the Royal College of General Practitioners (RCGP) Quality Practice Award (QPA), ISO 9001:2008 certification for its quality management system, and

Summary of findings

an Investor in People (IIP) award. QOF data for this practice showed the practice was performing exceptionally high, achieving an overall score of 100% in the 2014 /15 year.

- The practice had completed a smoking cessation audit within the last year which had led to increases in the numbers of people completing the course and remaining as non-smokers.
- We found the practice outstanding in its care of People experiencing poor mental health (including people with dementia) because they had recognised the stigma surrounding poor mental health and had worked with local enterprises to work to ensure people were better informed.

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. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe. Risks to patients who used services were assessed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with its patient participation group (PPG).

Patients said they found they were able to get an appointment within a reasonable time, with urgent appointments available the same day. However some comments we received from patients highlighted the need for greater continuity in their care, by being able to see regular GPs and GPs of their choice.

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The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

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.

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 patient participation group (PPG) was active. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Patients over the age of 75 had a named GP, were flagged on the practice electronic records system and received prioritised access to appointments. The practice offered health checks to their patients over the age of 75. They also provided Dementia screening, chronic diseases management and medication reviews. For patients who needed additional support with taking and managing their medicines, dossett boxes could be organised.

The practice referred elderly patients who lived alone and were at risk of isolation to befriending services. The practice also supported their older patients that needed additional support to access the services available through Social Services.

The practice achieved over 76% for flu vaccination and 85% pneumonia immunisation coverage among the over 65s in the year ending 31 March 2015, which was well above the local area (Croydon) and London averages.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There is a high prevalence of people with long-term conditions being managed with their care provided by the GPs, nurses and healthcare assistant. The practice regularly maximised their QOF achievement in chronic disease management.

The practice worked closely with the community diabetic, respiratory, and heart failure teams and they made referrals to these services according to their protocols. The practice also maintained their strong links to the community teams having offered themselves as a pilot practice for consultant led quarterly virtual ward rounds. Complex cases were discussed during weekly practice clinical meetings.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Members of staff from the practice team attended the local CCG training events. They told us this raised their awareness of best practice as well as providing an opportunity for them to engage in discussion about local care pathways for patients. They told the access the CCG website and their own intranet site for up-to-date information on local protocols, pathways and referral management.

Families, children and young people

Good

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

The practice performed well for childhood immunisations, and their immunisation rates were relatively high for all standard childhood immunisations.

The practice provided shared antenatal care with the community midwifery team for low risk pregnancies, and for the provision of mother and baby postnatal care. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice were among the highest Chlamydia screeners in Croydon, identifying a number of positive cases who were treated and avoided health complications.

All clinical rooms in the practice had easily identifiable information on Child Protection procedures, namely whom to refer concerns to at both a practice level and externally in the local level. All staff were aware of the importance of making their concerns known to the named Lead GP or administrator in Child Protection or the Safeguarding Doctor and Nurse are available within the locality.

The practice reviewed child protection and child in need cases during their quarterly multidisciplinary meetings, to ensure that there was a named social worker and update information about the child's current status. Such multi-disciplinary team-working promoted the safety of their families and children.

Summary of findings

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.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice recognised that their population of working age people (including those recently retired and students) found it harder to attend the surgery and wanted to be able to communicate with the surgery easily having access at a convenient time. They told us that if this was not provided they were less likely to attend to their health.

The practice did not close for period of time (such as lunchtime) during opening hours, which meant working patients were able to contact them throughout the day. The practice promoted the use of their online services among their patients. They provided a computer terminal in the practice for patients who did not have personal online access, to be able to access their online services and resources. The practice website promoted on-line appointment booking and cancelling, requesting repeat medications, patient registration, amongst other facilities.

The practice provided extended opening until 8pm on Mondays, Tuesdays and Wednesdays and from 9am to 1pm on Saturdays.

The practice operated a “Duty-Access” clinic, which allowed those that were not able to find time to visit the surgery, telephone access to a GP for advice. Those who accessed this service were assessed and provided with a GP appointment at the practice if clinically required.

The practice supported out of area registrations. This allowed registered patients who moved away, such as those attending University or relocated for work purposes, to remain on their list. This supported patient choice and continuity of care. Additionally those that worked in the local area but lived elsewhere were able to register with the practice.

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 including homeless people, children living in vulnerable circumstances and

those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. The practice offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People whose circumstances may make them vulnerable were coded on appropriate registers. The practice had undertaken a recent audit in this area, particularly looking at children in vulnerable circumstances, to ensure they were currently identified in their records. All staff were encouraged to consider vulnerability issues with patients and to flag them up for discussion within the appropriate setting.

The practice worked in multi-disciplinary teams (MDTs) in the care of people in vulnerable circumstances. They held monthly MDT meetings to discuss the care of these patients.

The practice had implemented the learning from mental capacity act (MCA) training, and was acting as a pilot site for the new local CCG MCA assessment programme.

The practice told us they had received positive feedback about their work with and for people who were in vulnerable circumstances from external stakeholders. This included from their former local CCG child safeguarding lead and from the local hospice home care team.

The practice offered interpreters, on site and via language line. The practice website had functionality making it easily translated into a range of languages.

The practice allowed homeless people and travellers that were residing in the area to register with them, without putting barriers up to registration, such as requesting documentation these people may not have readily available.

The practice provided assistance to local charities that request medical reports or letters of support without applying a private work fee.

The practice have a shared care arrangement for substance misuse clients with the local provider.

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The practice have accommodated Croydon Citizens Advice Bureau (CAB) on site in their surgeries, providing their patients easier access to the CAB service.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice had available data for their QOF performance for patients with mental health needs for the year ending 31 March 2015, although this information had not been published at that time. For that period, 92.5% of these patients had had a comprehensive care plan developed with them in the preceding 12 months. In the same period, 92.7% and 97.5% of these patients respectively had had a record of their blood pressure and alcohol consumption.

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. Staff had received training on how to care for people with mental health needs and dementia. The practice had implemented the learning from mental capacity act (MCA) training, and was acting as a pilot site for the new local CCG MCA assessment programme.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

The practice maintained registers of people experiencing poor mental health (including people with dementia). This facilitated regular reviews where they optimised physical, social and psychiatric needs. For example, their latest QOF data (for the year ending 31 March 2015) showed that 79% of their patients diagnosed with dementia had had their care reviewed in the preceding 12 months. In addition, all of their patients with a new diagnosis of depression (made within the last 12 months) had had a bio-psychosocial assessment by the point of diagnosis. The practice received full QOF scores in Mental health and Depression.

Patients diagnosed with mental health needs had alerts added to their records. Any concerns about these patients were discussed during the practice regular clinical and MDT meetings.

The practice recognised that the locally commissioned talking therapies service had huge waiting lists and were not available to

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patients in a timely manner. They told us they had fed this back to the commissioners and offered their support to resolve these issues. One of the issues was the lack of room space locally for these services, and the practice told us they had offered their own clinical rooms to be used by the talking therapies service. Furthermore, the practice provided an in-house counselling service.

The practice have teamed up with Maslaha, a social enterprise to tackle immediate health and social issues affecting Muslim communities, especially around mental health, which is often seen as taboo. Together with patients, clinicians, and faith groups they had co-produced a short film, “Talking from the heart” exploring mental health diagnosis and therapy by combining medical and faith advice.

Summary of findings

What people who use the service say

We looked at the results of the national GP patient survey published on 08 January 2015. This contained aggregated data collected from January to March 2014 and July to September 2014. For the AT Medics GP practice at Parkway Health Centre, there were 452 survey forms distributed and 98 forms were returned. This is a response rate of 21.7%.

We received 20 CQC comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. Most of the comments cards were entirely positive, with patients saying they received a consistently good service, felt satisfied with the care they received, and that the staff team kept a good attitude, and were helpful and attentive to their needs. A few of the comments cards also included less positive comments but there was no theme to these.

We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Data from the national GP patient survey aligned with these views and showed that the practice performed particularly well against the local area and national averages for most aspects of care.

Parkway Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The other members of the team were a GP specialist advisor and a practice management specialist advisor.

Background to Parkway Health Centre

The AT Medics GP practice is one of three GP practices in Parkway Health Centre, located in New Addington in the London borough of Croydon.

At the time of our inspection there were 5323 patients registered in the practice. The practice population age distribution was similar to the national profile, with the exception that the proportion of the younger population, those aged between 0 and 24, were higher than the national average.

The practice had a personal medical services (PMS) contract for the provision of its general practice services. The AT Medics GP practice at Parkway Health Centre is registered with the Care Quality Commission (CQC) to carry on the regulated activities of Diagnostic and Screening procedures, Maternity and midwifery services, and Treatment of disease, disorder or injury to everyone in the population.

The practice staff team were six GPs, three of whom were female; an all-female nursing team of two nurses and two healthcare assistants, and an administrative team which included a practice manager, a quality assurance coordinator, and four reception and administrative staff members.

The AT Medics GP practice at Parkway Health Centre is open 08.00am to 8.00pm on Mondays to Wednesdays, 08.00am to 6.30pm on Thursdays and Fridays, and 09.00am to 1.00pm on Saturdays.

The practice had opted out of providing out-of-hours services to their patients. Patients were directed to contact the national free-to-call medical helpline, 111, when the practice was closed.

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.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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:

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 May 2015. During our visit we spoke with a range of staff (GPs, nurses, healthcare assistants, practice manager, quality assurance coordinator, and reception and admin staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incident was reported by a GP in April 2014 when they found swabs were out of date when they prepared to take a sample from a patient.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the last 12 months preceding our inspection. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held annually to review actions and themes from past significant events. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all 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

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. The practice manager was safeguarding admin lead. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, and information about the availability of chaperones was visible on the waiting room noticeboard 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). All nursing staff, including health care assistants, had been trained to be a chaperone.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the borough child protection lead.

Good

Are services safe?

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

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.

Records showed that all members of staff involved in the prescribing process had received appropriate training and their competence was checked regularly.

The practice carried out a range of medicines and prescribing audits as part of their annual audit programme. They showed us recent audits of pregabalin and benzodiazepines that had been carried out in the practice. The pregabalin audit identified practice improvements were required to comply with published guidelines, and they were implemented. The benzodiazepines audit identified that a large proportion of the patients on the medicine had it prescribed on repeat. This was reviewed and the practice was able to reduce the overall numbers of patients on the medicine and ensure those remaining on the medicine were not prescribed it on repeat for the long term.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The QA coordinator ensured cleaning schedules and audits of the domestic cleaning were completed. He told us that he also met with the cleaning team twice monthly to discuss the cleaning quality and bring up any concerns.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection prevention and control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out annual IPC audits, with the most recent audit having been completed in March 2015. Actions identified included to change some of the hand wash basins in the clinical rooms to basins of suitable specification, and to remove the carpeting in one of the admin rooms.

The IPC lead maintained contact with IPC lead in the community health team and within the local clinical commissioning group (CCG).

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last legionella risk assessment was undertaken in the practice in November 2014.

Equipment

Staff we spoke with 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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, September 2014.

A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that some recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards for recruiting clinical and non-clinical staff. We found that these processes were followed in the recruitment of new staff.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

There were arrangements in place for the induction of new staff, which was led by more senior and experienced members of the staff team such as the practice manager.

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. These included annual and / or monthly checks of the building, the environment, display screen equipment, medicines management, staffing, dealing with emergencies and equipment. The responsibility for health and safety risk assessments was that of the practice quality assurance (QA) coordinator. A full practice risk assessment was completed in October 2014, which included the review of arrangements for accidents and emergencies, hygiene and welfare, control of contractors, slips and falls, violence and fire.

As the practice premises was leased, the landlords for the building shared the responsibilities for health and safety and building maintenance with the practice. An asbestos risk assessment was carried out by the landlords in November 2013.

The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative, the QA coordinator.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support, with the most recent practice based session being completed on 12 May 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they carried out regular fire alarm testing.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. 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 saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of weekly clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of 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, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and practice administrator to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last two years; the first was on child protection and the second on smoking cessation. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The first cycle of the child protection audit was undertaken in June 2014 and its aim was to make sure children at risk are identifiable to all staff, thus enabling a heightened sense of vigilance when dealing with them in any capacity. The first cycle of the audit which compared data obtained from the health visiting team and compared it with the information on the electronic records system demonstrated that there were some discrepancies in the recording of information for the three groups of children reviewed in the audit: those on child protection plans, those classed as being 'in need', and those children who were 'looked after'. 35 children has been classified as being on child protection plans in the electronic system, when the true figure was three; no children were coded as being 'in need 'on the records system, whilst the true figure was five, and no children were coded as 'looked after' on the

electronic system whilst the true figure was 10. None of the children who met the audit criteria had yellow flags against their records highlighting their particular circumstances to staff when they accessed their records.

The results were discussed among the clinical team and a plan was developed which involved the practice manager taking a lead in coding to records all relevant information from child protection correspondence. The children not identified on the records system had their details entered. The health visitor child protection lead was contacted to supply the practice with an up to date list of children at risk to use in updating the records.

A second cycle of the audit was completed in December 2014. The patient records were now up to date and there were no discrepancies in the recording of information for the three groups of children reviewed in the audit.

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). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice undertook the first cycle of the smoking cessation audit in December 2013. The audit was carried out to review the effectiveness of the practice's smoking cessation policy. The audit criteria was that participating patients complete a smoking cessation course in line with their smoking cessation management plan, and that they remain ex-smokers. The first cycle of the audit found that of the 32 patients who engaged in smoking cessation at the practice, 18 completed the course, and 15 were recorded as quitters. Of those 15 patients, 12 remained ex-smokers at the time of the audit. This equated to a 56% completion rate for the course and an 80% rate of patients remaining non-smokers. The audit standard was 75% for each of these criteria.

In response to these results the practice were able to offer additional evening appointments for their smoking cessation clinics. Doctors were encouraged to identify patients and encourage them to book cessation appointments with the nurses and healthcare assistant. Smoking cessation advisors reiterated the importance of commitment from patients to complete the course when starting the process.

In December 2014 the practice carried out a further review of the patients on their smoking cessation programme. They found that of the 35 patients who engaged in smoking cessation at the practice, 23 completed the course, and 19 were recorded as quitters. Of those 19 patients, 15 remained ex-smokers at the time of the second cycle audit. This equated to a 65% completion rate for the course and a 78% rate of patients remaining non-smokers.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. The practice had available data for their QOF performance for the year ending 31 March 2015, although this information had not been published at that time. It achieved 100% of the total QOF target in the year ending 31 March 2015.

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.

The practice's prescribing rates were also similar to national figures. For example, for the year ending 31 December 2014, the practice had an average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) of 0.09, which was similar to the national average of 0.28.

The number of Ibuprofen and Naproxen Items prescribed as a proportion of all non-steroidal anti-Inflammatory drugs items prescribed in the practice was 91.4, whilst the national average was 75.13. The proportion of Cephalosporins & Quinolones Items as a proportion of antibiotic items prescribed in the practice was 3.87, whilst the national average was 5.33.

Good

Are services effective?

(for example, treatment is effective)

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, such as patients who were homeless and those with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions, such as those with diabetes, chronic obstructive pulmonary disease (COPD) or hypertension.

The practice participated in local benchmarking of their performance in comparison to other local practices operated by the same provider. This is a process of evaluating performance data from the practice and comparing it to similar surgeries. This benchmarking data showed the practice had outcomes that were comparable to other comparative services.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and the staff training matrix and saw that staff mandatory courses included annual basic life support, health and safety, infection control and safeguarding. Records showed that some staff were due for training updates on certain topics, and that the practice was awaiting new training dates to be made available by their local CCG.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a teaching practice, they provided placements to doctors in GP specialist training. At the time of our inspection, they had a GPST-1 trainee in post.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, providing smoking cessation advice and supporting the ongoing monitoring and review of patients with long term conditions. Nursing staff were able to demonstrate that they had appropriate training to fulfil these roles.

The practice offered fortnightly in hours training sessions for all clinical staff to ensure suitable standards of clinical care. The provider runs a healthcare assistant and nurses development support (HANDS) programme. The programme supports staff to develop their clinical competencies, IT skills, ensuring patient safety, and implementing robust clinical governance framework.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

The practice provided a range of in house and mandatory courses for their staff team. These included training in customer care and fire training that was provided by the practice QA coordinator.

The practice manager had responsibility for three of the provider's GP surgeries within the local area, and spent close to two days in each practice in a week.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and

Good

Are services effective?

(for example, treatment is effective)

letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were similar to expected and comparable to the national average. The practice had an emergency cancer admissions rate for year ending 31 March 2014 that was as expected and comparable with the national average rate. The practice had an emergency admissions rate for 19 Ambulatory Care Sensitive Conditions of 19.8 per 1000 patients; and was comparable with the national average rate was 14.4 per 1000 population.

The practice was engaged with local initiatives centred on community development, such as the asset based community development (ABCD) scheme. ABCD is a methodology recognising that in every neighbourhood there is a wealth of human, associational and institutional assets that should be identified, connected and mobilised for the benefit of that community and before seeking help from outside.

The practice was one of 21 GP practices operated by the provider, AT Medics Limited. The practice staff held regular meetings with two other AT Medics Limited practices in the local area. The practice staff attended monthly pan London meetings with their associated practices in Croydon, Streatham and West London. They told us that all the practices attending submitted a performance dashboard which was shared, reviewed and discussed at the meeting. They told us they found the meeting to be a good shared learning exercise.

The practice volunteered to pilot local CCG initiatives and models of care, prior to their roll out in the local area. They had piloted the diabetes care service, which led to the current model of care in the local area. Practice staff attended whole CCG meetings held every two months.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice was signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Good

Are services effective?

(for example, treatment is effective)

The practice was a pilot site for the new local CCG MCA assessment programme. This involved them piloting the use of the mental capacity assessment process and associated documentation developed by the CCG prior to its roll out across the local area.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 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 and insertion of intrauterine contraceptive devices (IUCD), 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.

Health promotion and prevention

It was practice policy to offer a health check to all new patients over the age of 40, and to those outside of this age range who wish to have the check. The GPs were informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged between 40 and 74 years.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 93% of patients on their co-morbidity register. Of their total patient population identified as smokers, all had been offered smoking cessation therapy. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening of its patients in the eligible group was 81.5% in the year ending 31 March 2014, which was similar to the national average of 81.88%. The practice performance included 92% of their patients with mental health problems.

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. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- For the period 01 September 2014 to 31 January 2015, the flu vaccination rates for patients aged 65 years and older were 76%, and at risk groups 63%.

For the year ending 31 March 2014, childhood immunisation rates for the vaccinations recommended for children aged two years and younger ranged from 84.5% to 94.6% and five year olds from 82.7% to 92.6%. These were comparable to the local CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction, in the form of the national GP patient survey and the most recent practice survey. For the national GP patient survey, 452 survey forms distributed for the AT Medics GP practice at Parkway Health Centre and 98 forms were returned. This is a response rate of 21.7%. The national GP patient survey results were published in January 2015. The practice survey, of 33 patients, was undertaken between November 2014 and March 2015.

The evidence from the GP patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 84.9% of respondents described their overall experience of the practice as good. This was better than the local area average and similar to the national average.

The practice was rated above average for its satisfaction scores on consultations with nurses, but rated below average on their satisfaction scores on consultations with doctors. For example:

- 93.8% said the nurse gave them enough time compared to the CCG average of 91% and national average of 91.9%.
- 96.3% said they had confidence and trust in the last nurse they saw compared to the CCG average of 96.4% and national average of 97.2%
- 98% said the nurse was good at listening to them compared to the CCG average of 90.4% and national average of 91%.

- 74.2% said the GP gave them enough time compared to the CCG average of 84% and national average of 86.8%.
- 90.3% said they had confidence and trust in the last GP they saw compared to the CCG average of 93.4% and national average of 95.3%
- 79.8% said the GP was good at listening to them compared to the CCG average of 86.2% and national average of 88.6%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards and the majority were positive about the service experienced. Patients said they felt the practice provided a satisfactory service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. However some comments were less positive with patients highlighting the need for greater continuity in their care, by being able to see regular GPs and GPs of their choice. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Additionally, 84.7% of the national GP patient survey respondents said they found the receptionists at the practice helpful, which was similar to the local area and national averages.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well, and at similar levels to the national averages, in these areas. For example:

Good

Are services caring?

- 82.4% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.2% and national average of 86.3%.
- 76.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81.5%.

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 told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was mostly positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 79.7% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81.9% and national average of 85.1%.
- 92.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88.7% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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 patients' 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. In response to their most recent patient survey results, the practice had provided staff training in dignity and respect, and supported their administrative and reception staff that had not yet completed it, to achieve their NVQ level 2 in customer care. They were also further promoting their online services and range of services available to patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice organised a series of open meetings during the summer of 2014 to discuss with their patients opportunities for participation and involvement.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or those who expressed the need for a longer appointment to discuss a number of issues.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The practice was accessible to patients who were wheelchair users, and was all located on the ground floor level. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

Access to the service

The surgery was open 08.00am to 8.00pm on Mondays to Wednesdays, 08.00am to 6.30pm on Thursdays and Fridays, and 09.00am to 1.00pm on Saturdays.

The practice did not close for period of time (such as lunchtime) during opening hours, which meant working patients were able to contact them throughout the day. The practice promoted the use of their online services among their patients. They provided a computer terminal in the practice for patients who did not have personal online access, to be able to access their online services and resources. The practice website promoted on-line appointment booking and cancelling, requesting repeat medications, patient registration, amongst other facilities.

The practice provided extended opening until 8pm on Mondays, Tuesdays and Wednesdays and from 9am to 1pm on Saturdays. This was above their contractual requirements.

All GPs in the practice had slots reserved for telephone consultations. To support patients to get appointments with their preferred GP, the practice rotated the appointment days of their GPs.

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 website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This included appointments with a named GP or nurse.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 89.3% were satisfied with the practice's opening hours compared to the CCG average of 75.3% and national average of 75.7%.
- 89% described their experience of making an appointment as good compared to the CCG average of 72.6% and national average of 73.8%.
- 95.1% said they could get through easily to the surgery by phone compared to the CCG average of 75.6% and national average of 74.4%.
- However only 50.6% said they usually waited 15 minutes or less after their appointment time, compared to the CCG average of 59.8% and national average of 65.2%.

The feedback from the practice patient survey also aligned with these views. For example, 78.79% of respondents felt they practice always or usually provide accurate and up to date information on services and opening hours.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice waiting area was shared with two other GP practices and Croydon health services that were all based at Parkway Health Centre. There was clear signage indicating which reception area was for each service.

Information about the practice's appointment and opening times were displayed in the waiting area, as well as health promotion information and notice about the availability of chaperones to be present at patient consultations if they required.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet available and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the five complaints received in the last six months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaints. Lessons learnt and actions taken in response to complaints were recorded and the practice management discussed learning with staff individually and during staff meetings.

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 clear aims and objectives set out in their Statement of Purpose which included delivering high quality accessible care using innovative solutions to respond to patients' needs, as well as investing in their staff through structured coaching, leadership and training.

The members of staff we spoke with all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

There was a senior management team in place with leadership responsibilities across all of the provider's locations (practices). The senior management team had oversight of policies and procedures required and implemented across the organisation. All staff had access to the organisation's policies and procedures which were held electronically on a shared computer drive. We looked at a number of policies and procedures and staff explained the process in place to ensure all staff read relevant policies and procedures for their roles. All the policies and procedures we looked at had been reviewed and were up to date.

The practice has ISO 9001:2008 certification for its quality management system. This meant they followed globally recognised quality management principles which influenced how they operated the practice including the creation and revision of policies and procedures, audits of systems and processes and maintaining patient focus.

The practice achieved the Royal College of General Practitioners (RCGP) Quality Practice Award (QPA) in 2013. The award is given to general practitioner practices in the United Kingdom to show recognition for high quality patient care by all members of staff in the team. The QPA is the highest attainable award from the RCGP, and recognises practice teams who have demonstrated both clinical and organisational excellence in the delivery of primary care.

The practice also has an Investor in People (IIP) award. The IIP is an accreditation that recognises the work an organisation does in empowering its employees to be at their best.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. They completed regular clinical audits to improve outcomes such as the examples they shared with us of a child protection audit and a smoking cessation audit.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance, and performed highly against set targets. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice had arrangements for identifying, recording and managing risks. The practice had a quality assurance coordinator, whose role included health and safety risk assessment and management. We saw evidence that as a result of their assessments, actions were identified and improvements were made in the practice's operation.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had gathered feedback from patients through the Friends and Family test (FFT). The Friends and Family Test is a nationally implemented feedback tool for NHS services, introduced in GP practices on 01 December 2014. The practice also sought patient feedback through its own patient surveys, comment cards and complaints received.

We looked at the results of the most recent practice patient survey, results for which were collected between November 2014 and March 2014. The survey had 33 respondents. The results showed that 75.76% of patients said they were either likely (or above) to recommend the practice to friends or family, 78.79 % of patients felt the practice always or usually provided accurate and up to date information on services and opening hours. The practice patient survey results were reviewed in a practice meeting and the staff decided on a number of improvements in response to the survey findings. Improvements implemented included running "duty access" clinics where every patient who wants to speak to a GP is able to, providing staff with further training in customer care, and further promoting their online services.

The practice had an active patient participation group (PPG) which met quarterly. The practice responded to feedback and matters raised by PPG members, and supported them to organise and stage their own health promotion events at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical and professional development through training and mentoring. At the time of our inspection two of the practice HPs were being mentored to become training supervisors for GPs in training. The practice had took part in the government apprenticeship scheme and offered placements to apprentices in administrative roles.

We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended.

In January 2013 the practice was accredited for four years as a teaching practice by the London Deanery.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.