Millfield 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 Millfield Medical Centre on 12 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to require improvement for providing safe services. It was good for providing effective, caring, responsive and well led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to health and safety issues and some areas of infection control.
- Data showed patient outcomes were average for the locality. Although some audits had been carried out, there were no completed audit cycles to help drive improvement.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had considered the needs of its diverse population. They were also the designated practice by the local authority for migrants and patients who were seeking asylum and had developed strong working links with other agencies such as the police, local authority housing and the Red Cross.
- Information about services and how to complain was available. This information had been translated into some of the most common languages used by the registered patients.
- Urgent appointments were usually available on the day they were requested. However patients said that they had difficulty getting through on the telephone.

Summary of findings

- The practice had a number of policies and procedures to govern activity. However we found that some policies relating to infection prevention and control and medicines management were not in place.
- The practice had a meeting structure in place to monitor the quality of services being provided. However, this was not embedded across the staff team.
- The practice were proactive in seeking the views of their patients and used their feedback to shape services.

We saw areas of outstanding practice:

The practice had an ethnically diverse population and the staff were mindful of this in the way they supported people to access medical services. This meant that patients received support to achieve the best health outcome for them based on their individual need. The practice recognised that patients' psychological and emotional well-being had a direct effect on their health and had developed social interventions at their community centre. This was particularly beneficial to patients in vulnerable groups. For example:

- information sessions were provided in Urdu and Punjabi so that carers had a greater understanding of patients with dementia.
- there was an established exercise group for Asian women. We received comments cards completed by attendees that demonstrated four people had lost weight and their overall health and well being had improved.

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

The areas where the provider must make improvements are:

- Review and strengthen the infection control procedures to ensure that staff have access to current guidelines and there are systems in place to assure the provider that effective cleaning procedures are in place for all aspects of the practice.
- There must be an up to date record to demonstrate staff immunity against Hepatitis B.
- Improve the non-clinical health and safety risk assessments that are in place to ensure that potential risks for staff, patients and visitors to the practice are identified and managed.

In addition the provider should:

- Develop and implement a relevant clinical audit plan so that audit findings can be used to improve patient outcomes.
- Complete a more detailed analysis to improve the learning outcomes following significant events and complaints and ensure these are more widely shared.
- Ensure the new leadership structure which includes lead roles, is communicated clearly to staff.
- Strengthen team communication and involvement with service developments. Ensure that all staff know how to access policies and procedures.

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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although most risks to patients who used services were assessed and well managed, systems to manage infection control risks and health and safety risks were not implemented well enough to ensure patients were kept safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were variable compared to average outcomes for the locality. The practice told us this was in part, due to the specific circumstances of the diverse patient group, although we found improvements could be made to monitoring diabetes care. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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 planned for. 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. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available at the practice was accessible to them in a range of languages. We also saw that staff treated patients with kindness, respect and compassion 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 the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. They considered the needs of the diverse patient population and took steps to adapt the service to meet their needs for example by

Summary of findings

employing a health and wellbeing coordinator to work with black and ethnic minority groups. Some patients said they found it easy to access an appointment but others could not get through on the phone.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available to patients. The practice responded quickly to issues raised and welcomed the views of their patients. Learning from complaints could be further improved.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and a strategy in place and staff demonstrated they shared the same view. There was a leadership structure in place although this was not embedded as it had recently been reviewed. Staff felt supported by management but told us day to day communication was not always effective. The practice had a number of policies and procedures to govern activity although we identified some gaps and updates to content were required to reflect national guidelines. Meeting structures were in place. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and an annual performance review.

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 had a small population of older patients registered with them compared to the national average rates. They remained focused on meeting the needs of this group and provided continuity of care through the support of a practice based community matron.

There was clear evidence of partnership working with other agencies such as Age UK, the Carer's Trust and the Alzheimer's Society.

The practice also worked with families and carers to help alleviate their anxiety and increase their knowledge and understanding of conditions. For example by providing information sessions in Urdu and Punjabi so that carers had a greater understanding of dementia.

The practice's information team used their patient data to help improve the quality of the service. For example, a system was in place to help identify the most vulnerable elderly patients who may require access to urgent care and following hospital discharge, check information and arrange home visits to them if appropriate.

Support and advice was available to patients though the community health and well-being co-ordinator and groups provided at the practice's community centre.

People with long term conditions

Good

The practice had a system in place to monitor patients with long term conditions such as asthma and heart disease. Practice nurses followed up to date clinical protocols and were appropriately trained. There was a system in place to conduct reviews for patients at regular intervals and those with several conditions could be seen in one long appointment if this was more convenient. Diagnostic tests could be provided such as diabetes, spirometry, urine tests and ECGs.

A diabetes nurse specialist ran regular clinics at the practice and nurses offered home visits for housebound patients. Other support for this patient group included education in the community centre about managing diabetes and reducing other health risks.

The practice was involved in other partnership work with community organisations to help raise awareness about long term conditions such as mental health, diabetes and dementia.

Families, children and young people

Good

The practice is rated as good for the care and support of families, children and young people. They had a high number of registered patients in this population group and had made adjustments to

their service in response to this. For example, a weekly baby clinic was held in a designated 'mother and baby' space within the practice. They had also introduced a mother and baby triage nurse to help manage appointments and provide appropriate advice.

The practice had taken steps to understand the needs, expectations and beliefs of their diverse population to promote preventative health measures such as childhood immunisation programmes and attendance for cervical smear tests. For example a member of staff who spoke Polish phoned eligible patients to educate them about cervical smear testing and encourage them to book a test.

The practice staff had established relationships for joint working with the health visitors and midwives who were based in the building.

Patients we spoke with told us that staff were supportive and they were able to access appointments for their children.

A range of health and social care advice could be accessed in the practice's resource centre such as the Citizen's Advice Bureau and the Richmond Fellowship. Mothers also had access to groups such as the National Childbirth Trust, a mothers yoga group and 'Connecting Mums' groups.

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. Extended opening hours were available in the evenings to accommodate working patients' needs and those with family commitments. Online services included appointments, requests for repeat prescriptions and telephone consultations were also offered. The resource centre based in the practice offered a range of information about local and national groups to support patients health, social and welfare needs. This included support from the Citizens Advice Bureau and the police. The community centre owned by the practice was also used by a range of groups for example Lithuanian Alcoholics Anonymous group and the Czechoslovakian Embassy.

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. They are the designated practice by the local authority for migrants and patients who were seeking asylum and had taken steps to work with others

to ensure their health and well-being needs were met. For example they were part of a multi-agency forum between the police, local authority housing and the Red Cross. They also worked closely with charities supporting young asylum seekers and unaccompanied children.

The practice owned premises nearby that were used to support people who may feel isolated and vulnerable and encourage them to seek help and meet others in a safe space. The centre was also used by the police to address issues relating to trafficked workers and women. Practice staff had received awareness training about these issues from local police so they could identify and support this vulnerable group.

The practice provided longer appointments for vulnerable patients who may need more time to express their needs and concerns. Several members of staff spoke alternative languages, an interpreting service was available and staff provided some information in alternative languages.

Vulnerable patients were also supported by the community health and well-being co-ordinator and the community matron. The practice regularly worked with multi-disciplinary teams by reviewing the case management of vulnerable patients.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Information to signpost vulnerable patients to access support groups and voluntary organisations was readily available through the resource centre. Staff knew how to recognise signs of abuse in vulnerable adults. They understood the issues faced by some of their patients such as overcrowded housing and the impact this had on their health. This meant they could respond sensitively and work with other agencies to promote their safety and welfare.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Annual physical health checks were offered to patients with long term mental health needs although less than half of these patients had taken up the offer in the last year partly because patients declined and also due to them not attending appointments. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

Partnership working was in place with the community health and well-being co-ordinator and the Alzheimer's Society to raise awareness and understanding of dementia for patients and families from other minority backgrounds.

Patients were supported to access information and support from groups such as MIND, Richmond Fellowship, councillors and local NHS Mental Health team.

Summary of findings

What people who use the service say

We spoke with nine patients as part of the inspection process and we received 13 completed CQC comment cards. Patients told us the practice staff were caring, respectful and helpful and they were happy with the advice and treatment they received.

However, three patients said they had difficulty accessing an appointment. Parents said they had difficulty getting through on the telephone in the mornings before the school run which meant appointments were booked by the time they called back.

Areas for improvement

Action the service MUST take to improve
Action the provider MUST take to improve:

- Review and strengthen the infection control procedures to ensure that staff have access to current guidelines and there are systems in place to assure the provider that effective cleaning procedures are in place for all aspects of the practice.
- There must be an up to date record to demonstrate staff immunity against Hepatitis B.
- Improve the non-clinical health and safety risk assessments that are in place to ensure that potential risks for staff, patients and visitors to the practice are identified and managed.

Note: detailed actions will be written in detailed findings section of the report.

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Develop and implement a relevant clinical audit plan so that audit findings can be used to improve patient outcomes.
- Complete a more detailed analysis to improve the learning outcomes following significant events and complaints and ensure these are more widely shared.
- Ensure the new leadership structure which includes lead roles, is communicated clearly to staff.
- Strengthen team communication and involvement with service developments. Ensure that all staff know how to access policies and procedures.

Note: detailed actions will be written in detailed findings section of the report.

Outstanding practice

The practice has an ethnically diverse population and the staff were mindful of this in the way they supported people to access medical services. This meant that patient's received support to achieve the best health outcome for them based on their individual need. The practice recognised that patients' psychological and emotional well-being had a direct effect on their health and had developed social interventions at their community centre. This was particularly beneficial to patients in vulnerable groups. For example:

- information sessions were provided in Urdu and Punjabi so that carers had a greater understanding of patients with dementia.
- there was an established exercise group for Asian women. We received comments cards completed by attendees that demonstrated the value this had on their health and well being.

Millfield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor and a specialist practice management advisor.

Background to Millfield Medical Centre

Millfield Medical Centre is situated in the centre of the city of Peterborough and provides services to approximately 12,000 patients. The patient population has a diverse range of cultures with 80% of patients who do not speak English as their first language. There are also much higher than average numbers of patients aged 20-35 years and of children aged 10 years and under.

The practice team consists of 35 staff. There are three GP partners and three additional salaried GPs. (Two male and four female.) The nursing team included a community matron, two practice nurses, a triage nurse practitioner, a specialist nurse for mothers, babies and children and three healthcare assistants. The administration team is led by a practice manager and includes two dedicated data management staff and a reception team.

The practice holds a primary medical services contract and is the designated practice by the local authority for supporting migrants and asylum seekers.

The practice is open between 8am and 8pm Monday to Wednesday and from 8am until 6.30pm Thursday and Friday. When the practice is closed, patients are advised to call the 111 service in order to contact the out of hours service.

The practice had been previously inspected by CQC in February 2014 and were found to be meeting all the standards we reviewed at that time. We visited the practice at St. Martins Street, Peterborough Cambridgeshire PE1 3BF.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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:

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

Detailed findings

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 12 May 2015. During our visit we spoke with a range of staff which included; GPs, practice nurses, healthcare assistants, reception staff, data management staff and the practice manager. We also spoke with patients who used the service, observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients and members of the public shared 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, they reviewed and acted upon incidents and national patient safety alerts. They also responded to and took action following 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. We reviewed incident reports and minutes of staff meetings where safety issues were discussed. This showed the practice had managed safety issues consistently and provided 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. The practice manager was responsible for leading this. We reviewed records which showed six significant events had been reported since April 2014. Each one had been discussed at the monthly practice meeting attended by the GPs and practice manager. Learning points were recorded along with the actions taken. However when we tracked some of the incidents, we also found that lessons learned could be considered in more detail. For example, a patient review was delayed due to a breakdown in team communication. Recorded learning and the actions taken did not detail how the communication could be improved to prevent reoccurrence.

Staff we spoke with knew how to raise an issue using the incident reporting system.

National patient safety alerts were disseminated by the practice manager to relevant practice staff. We found that medicines safety alerts were shared with the prescribers and appropriate action was taken.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. A GP had lead responsibility for monitoring all safeguarding concerns. Training records showed that all staff had received relevant role specific training on safeguarding.

Members of staff we spoke with were able to demonstrate they were knowledgeable in identifying and recognising possible signs of abuse in older people, vulnerable adults and children.

Safeguarding policies were in place for children and adults at risk of abuse. These detailed how to deal with disclosures and reporting to the police and local authority. Local contact numbers of external partners such as social services were readily available and staff knew how to locate these if needed. The practice had a close working relationship with the local health visitor team who were based in the practice. This enabled them to work together to secure the needs of vulnerable children.

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. Staff were able to describe examples of concerns the practice had raised about vulnerable adults and how they had supported the investigation by the local authority to ensure the safety of vulnerable people.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Healthcare assistants employed at the practice acted as a chaperone if a registered nurse was not available. They had received training to undertake the role and DBS checks (Disclosure and Barring Service) had been completed. We spoke with some patients who were unaware of the chaperone policy offered to them.

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 did not vaccine refrigerators that were hard wired and there were no signs reminding staff to ensure the electrical supply was not switched off to protect the safe storage of the vaccines. Records showed fridge temperature checks were carried out daily. However, maximum and minimum temperatures were not being monitored on a daily basis to ensure vaccines were stored at safe temperatures at all times.

Requires improvement

Are services safe?

A practice nurse was responsible for checking the vaccine stocks, ensuring they were available, within their expiry date and suitable for use. However, there was no record of the process used if the member of staff responsible was unavailable. All the medicines we checked were within their expiry dates. Any expired and unwanted medicines were disposed of in line with waste regulations.

Since our inspection visit, the practice have taken swift action and have introduced a policy to ensure that these medicines are kept safely and at the required temperatures.

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.

Cleanliness and infection control

The premises were visibly clean and tidy. The practice employed their own cleaning staff and cleaning schedules were in place. The assistant practice manager was responsible for checking the quality of cleaning and supervising the cleaning staff. They told us that checks of the quality of the cleaning were completed every three months but they were unable to provide a record of this. Cleaning equipment was stored in a locked cupboard and followed NHS guidelines.

The practice had designated a member of the nursing team to lead on infection control practice and advise colleagues on best practice. We found the member of staff had not yet received any additional training and did not have this planned because they had only recently taken on the role. An infection control audit had not been completed within the last two years to monitor that safe infection control practice was being followed by staff.

We reviewed the infection control policy and supporting procedures, and found they did not encompass all aspects of the practice. These policies and procedures did include some helpful guidelines for example, the use of personal protective equipment and how to safely manage samples and specimens from patients when they were brought into the practice. However, the policy did not include reference to recent key guidelines such as the Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance. There were no written guidelines about the cleaning of clinical equipment and the treatment rooms. There was no systematic process in place to ensure that clinical cleaning was completed.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The practice did not have an up to date list of clinical staff with Hepatitis B immunity. They could not demonstrate that staff and patients were fully protected against Hepatitis B.

Notices about hand hygiene techniques were displayed in staff and toilets. Hand washing sinks with liquid soap, hand gel and paper towel dispensers were available in treatment rooms. However, we noted there were no hand wash notices or hand gel available in the patients' toilets.

The practice had procedures in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A recent risk assessment had been completed by the practice manager. We saw records that confirmed the practice was carrying out regular checks to reduce the risk of legionella infection to staff and patients.

Equipment

Staff we spoke with told us they had access to equipment to carry out diagnostic examinations, assessments and treatments. Equipment maintenance logs showed that items were tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was October 2014.

We saw evidence of calibration of relevant equipment; for example weighing scales, nebulisers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that detailed the standards it followed when recruiting clinical and non-clinical staff. We looked at six staff files and found that there were some gaps in recruitment checks undertaken prior to employment. There was no information about staff's previous employment history for three members of staff recruited within the past 12 months. One member of staff recruited within the past year had no documentary proof of identity.

Requires improvement

Are services safe?

The practice had a process in place to complete checks of staff through the Disclosure and Barring Service. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The checks were completed prior to their appointment and refreshed every three years.

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 on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice although further improvement was needed. The practice completed annual and monthly checks of the building, the environment, staffing, dealing with emergencies and equipment. However, there were no health and safety risk assessments in place that considered issues such as the risk of staff experiencing violence in the workplace or the risk of slips and trips hazards so that appropriate measures could be put into place to manage those risks.

Fire risks had been assessed and all fire fighting equipment was regularly serviced to ensure it was in safe working order. The practice manager had also consulted with a fire safety advisor and regular staff training was in place.

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. Emergency equipment was available and this included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff were aware of the location of this emergency 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 ensure that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There were systems in place that enabled staff to raise an alarm in an emergency situation either by phone or computer. However, some staff we spoke with were not confident in raising the emergency alarm system or knowing the expected procedure to follow if a patient was using aggressive behaviour towards a colleague.

Conversely, a visitor to the practice told us they had witnessed staff dealing with an abusive patient. They told us reception staff called for help and together, staff dealt with the situation calmly and effectively.

There was a business continuity plan in place that detailed the actions staff should take in any event that could disrupt the service such as loss of essential utilities, severe damage to the premises or unplanned sickness. It also covered succession plans for staffing the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with GPs and nursing staff who were able to describe their approach to clinical care and support that reflected best practice guidelines. They were able to demonstrate that they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners to ensure patients were receiving care in line with guidance. We saw evidence that showed new guidelines were disseminated to staff and any impact for patients were discussed at practice meetings.

We found that staff completed thorough assessments of patient's needs in line with NICE guidelines. The registered patient group were an ethnically diverse population and the staff were mindful of this in the way they supported people to access medical services. This meant that patients received support to achieve the best health outcome for them based on their individual need. The practice recognised that patient's psychological and emotional well-being had a direct effect on their health and had developed social interventions at their community centre to further support patients needs.

Specialist clinical areas of responsibility were shared amongst the GPs. For example, children's health, rheumatology and women's health. The practice nurses were skilled in providing clinics for patients with long-term conditions such as diabetes, leg ulcer management and respiratory conditions. One nurse also had specialist experience in supporting the health needs of mothers, babies and children and provided a triage service to help identify their needs and ensure they received appropriate advice or follow up care.

Clinical staff we spoke with said they were comfortable in providing colleagues with advice and support. The management team confirmed that they held lunchtime sessions for staff training and to review and share knowledge of best practice guidelines. Staff also met informally each day for a coffee break where they shared experiences and supported one another. The nurses met separately before clinics started to plan their day.

Staff we spoke with and records we reviewed showed that patient referrals for specialist assessment (for example for patients with suspected cancers) were reviewed by clinical staff. This helped to ensure that any improvements to practice were shared with staff. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were cared for and treated based on their individual need. The practice took account of patient's age, gender, race and culture as appropriate to ensure their needs were being met.

Management, monitoring and improving outcomes for people

The practice had completed an audit of antibiotic prescribing in response to a request from the Clinical Commissioning Group (CCG). This is a group of general practices that work together to plan and design local health services in England by 'commissioning' or buying health and care services. However the learning from the audit was not specifically linked to improving standards and a repeat audit, to complete the cycle had not been completed.

The practice did not use audit as a tool to help improve services but preferred to monitor services and outcomes for patients in other ways. This included for example, analysing data from the patient information system to use it in meaningful ways. One example of this looked at the number of consultations being provided to patients under the age of 45 years. This demonstrated a much higher demand from patients in other practices. In response, the practice increased their numbers of clinical staff to meet this demand.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. 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 e.g. diabetes and implementing preventative measures. The results are published annually. Data we reviewed with the lead GP showed that the practice had scored well in some areas but overall scores were below local and national averages for the management of patients with diabetes. In part, the GP explained this was due to the health beliefs of their population who had different lifestyle priorities. However, we found the process for checking individual patient follow up was not as systematic compared to other long term conditions and could be improved.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. Patients who received repeat prescriptions were reviewed by the GP on a regular basis. Staff also checked that all routine health checks were completed for patients with long-term conditions such as respiratory diseases and that the latest prescribing guidance was being used. GPs received medicine alerts through the computer system when prescribing medicines. This meant they were prompted to consider the use of the medicine and whether it was still relevant for individual patients.

The practice was using the gold standards framework for end of life care and a designated GP led on palliative care issues. A register of patients was in place so that staff were able to monitor on-going care and support needs for these patients and their families. Patients with more immediate needs were reviewed at monthly multidisciplinary meetings. Records we reviewed confirmed that palliative care meetings took place every three months. The practice told us they had good working relationships with the Macmillan nurse, palliative care doctors and community nurses.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed the staff training log which was managed by the practice manager's assistant. This detailed a range of mandatory training for staff and showed when the training was next due. The practice manager completed an annual training plan and this included additional as well as mandatory training needs and how these would be addressed for the coming year.

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 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).

The assistant manager had responsibility for checking the nurses registration with the Nursing and Midwifery Council (NMC) was renewed every year. The NMC is the professional body that holds the licenses for all nurses and midwives. A similar system was in place for checking GP appraisal and revalidation.

When we spoke with staff, they told us they had access to annual training updates and received emails from a member of the administration team to tell them when their training was due. They told us they were supported to complete developmental training if it was appropriate for the practice. For example a nurse had been supported to develop her skills and role as a community matron.

Staff had an annual appraisal completed that identified learning needs from which action plans for their training and development were documented.

Working with colleagues and other services

The practice worked with other health care services to meet patients' needs. There were systems in place to receive information such as blood test results, X-ray results, and letters from hospital either by post or electronically. There were further systems to ensure information was exchanged with the out-of-hours GP services and the NHS 111 service so that patients who had received support from those services continued to receive care from the practice in accordance with their needs. The relevant GP for the patient reviewed the information and took responsibility for taking any action required. When a GP was unavailable, another GP covered for them to ensure that results were checked and action was taken in a timely way. Staff told us this system worked well.

The practice held multidisciplinary team meetings each month. These focused on reviewing patients with complex needs, for example those with end of life care needs or vulnerable patients who have had an unplanned admission to hospital. The meetings were often attended by community nurses, Macmillan nurses, physiotherapists, occupational therapists and voluntary groups such as Age UK and the Richmond Fellowship. The practice also had a multidisciplinary team co-ordinator allocated to them by the CCG to support staff in their work to prevent vulnerable patients being admitted to hospital un-necessarily. We spoke with a representative from a local care home supported by the practice. They told us that staff responded to requests for visits in a timely way so that the health needs of patients registered with them, were met.

Good

Are services effective?

(for example, treatment is effective)

The practice worked closely with a wide range of agencies to support the need of their patients. For example Citizens Advice Bureau, Lithuanian Alcoholics Anonymous, Red Cross, Police and local housing associations.

Information sharing

The practice used electronic systems to communicate with other providers. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals including through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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 which had been introduced at the beginning of 2015.

Consent to care and treatment

Clinical staff we spoke with considered the diverse needs of their patient population and were mindful of the issues concerning consent to treatment. They were careful to make sure patients understood what they were consenting to before carrying out a procedure or referring them to another health professional. When a patient had limited understanding of the English language, this was done through using a translation service, a family friend of relative or another member of staff.

We also spoke with staff who were aware of the importance of judging a patient's capacity to make decisions due to a learning disability or through mental ill health. They were familiar with the process required for making best interest decisions and working with other health and care professionals to support the patient who was unable to consent to key decisions.

Health promotion and prevention

The practice planned services for their patients by considering their physical health and social wellbeing. In particular they had listened to patient stories so they had an understanding of the cultural beliefs and values of the diverse population. This had led them to purchase a community centre so that cultural groups could come together for social activities that would also promote their health and wellbeing. For example, an exercise group specifically for Asian ladies and a diabetic clinic.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Clinical staff described how they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and informing them about the services and activities available in the Beehive Community Centre. Eight out of 13 comment cards we received were from patients who used the centre. These contained positive comments about their experience of attending fitness classes and staff support to help them improve their health. Four comments cards indicated that patients who attended the Asian ladies fitness class, had lost weight and improved their health as a result of their attendance.

The practice offered NHS Health Checks to all its patients aged 40 to 74 years. During the previous year the practice had exceeded the target number of checks set by the CCG and had completed a total of 284 patient checks. If a patient was found to have any risk factors for disease identified at the health check, they were advised to have further investigations.

The practice kept a register of all patients with a learning disability and offered an annual physical health check. Out of 27 patients all were invited to attend and 15 had taken up this offer.

The practice had difficulty keeping in contact with some of their registered patients due to frequent changes of address. This made it difficult to send appointment reminders and follow up information. They took opportunities to remind patients to keep them updated about their personal details by displaying posters and adding information on their website.

The practice understood that the cultural beliefs and expectations of their diverse patient group influenced the way patients engaged with health promotion activities and

Good

Are services effective?

(for example, treatment is effective)

had taken steps to improve this. For example a member of staff who spoke Polish was getting involved in the cervical smear testing programme to encourage support and attendance by women from that community.

We spoke with a worker from a voluntary organisation who told us the staff often searched the internet for information in alternative languages and provided this to patients in a format they could understand.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the recent national GP patient survey in 2014. This showed that 21% (96 patients) of the patients invited to complete the survey had returned them. The results showed patients found it easy to get through to the practice by phone and make an appointment. When they attended for their booked appointments, most people were not kept waiting more than 15 minutes behind their appointment time. However, 43% patients said they did not get to see or speak with their preferred GP. The practice scored lower than local average scores (70% compared to 88%) for the number of patients who said they got an appointment to see or speak with someone the last time they called.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards. Five of these commented on the general service at the practice. Patients said the practice staff treated them with dignity, respect and were helpful.

We also spoke with nine patients on the day of our inspection. Three patients had limited English skills and interpreters were used to help us. This included an external interpreting service and a member of the practice team. All of the patients we spoke with told us that their individual needs were respected by the staff who always listened to them. One patient told us the nurses were very understanding and supportive.

We found that consultations and treatments were carried out in the privacy of a consulting room. Notices in waiting areas alerted patients that they could request a chaperone during an examination or treatment if they wished to do so. The role of a chaperone is to acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Some patients we spoke with were unaware that chaperones were available to them.

Staff were mindful of the practice's confidentiality policy when discussing patients' information to ensure that it was kept private. Patients' calls were received away from the reception desk which helped keep patient's personal details private. A waiting system was in place to allow only one patient at a time to approach the reception desk to reduce the risk of other patients overhearing private conversations.

We observed staff interacting with patients in the reception, waiting rooms and on the telephone. All staff showed genuine empathy, compassion and respect for people, both on the phone and face to face.

Care planning and involvement in decisions about care and treatment

Patients we spoke with during the inspection told us they felt the staff took time to talk with them and answered their questions. For example one patient who had limited English language told us a member of the nursing team spoke their language and helped them to understand health information.

Four patients told us they, or a close family member also registered with the practice, had been referred by a GP for treatment to a hospital. They had mixed experiences of this. Two patients told us their referral had been made swiftly and follow up care from the GP had gone smoothly. One patient told us they had requested a referral for a young relative whose symptoms were not improving. They felt the GP had been reluctant to do so, but once the referral was made to hospital swift treatment was provided. The third patient had experienced a delay because their referral had been overlooked by the practice.

When we spoke with staff they were sensitive to the needs of their registered patients with limited English language skills and mindful of the need to ensure consent. Translation services were available if required although several members of the practice team spoke alternative languages and could assist if the patient required additional support.

Patient/carer support to cope emotionally with care and treatment

We found the practice was sensitive to the holistic needs of their patients and the importance of meeting their emotional needs to improve their health and well-being.

The practice had taken steps to understand and support the diverse needs of their patients from vulnerable groups.

Good

Are services caring?

This included the development of links with stakeholders and voluntary groups such as a charity supporting young people seeking asylum, the British Red Cross, Public Health England and the police service.

The practice's community centre was used seven days a week by the local community. This enabled cultural groups across all age ranges, to meet together to seek support from one another. It also provided patients with easy access to support from local health and social care groups and community churches.

The practice had a register of carers and was able to signpost patients to seek additional support through local carers groups. This included patients with multiple caring responsibilities who may not speak English.

A worker from a local charity supporting asylum seekers told us that staff were very flexible and understanding of patients' needs. They confirmed that services were offered to this vulnerable group outside of the practice, for example a supper club was held at their Community centre.

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 continually reviewed so that systems were adapted to address identified needs in the way services were delivered. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice shared some details of work they were doing to improve childhood immunisations and attendance for cervical smear tests.

The practice had recognised they had a very high number of families with young children and had adapted the service accordingly. For example they ran a weekly baby clinic in a designated space and had introduced a mother and baby triage nurse to manage appointments and provide appropriate advice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with them to improve services and the quality of care. Many of the members of this group were recruited by the practice manager when they raised feedback about their experience of using the service. Examples of the changes made by the practice include improvement to mother and baby facilities, changes to the practice leaflet and the appointment system.

Tackling inequity and promoting equality

The practice had a culturally diverse range of registered patients, 80% of whom did not speak English as their first language. Some registered patients were new arrivals in the country in vulnerable situations. The practice had taken steps to recognise the needs of these vulnerable groups and ensure they worked with other services to meet their needs.

The practice had a community health and well-being co-ordinator who worked to bridge the gap between the service and needs of the Asian community. They provided information about the services available to help patients understand the health system and promote its' use. They also gave feedback to the practice about cultural needs and values so that staff could offer a more flexible approach to meet their needs.

Translation services were available for use although several members of the practice team spoke alternative languages. Many patients in this situation also brought along a reliable family member to help communicate with practice staff. The practice website could be translated into a very wide range of languages including Urdu, Gujarati, Lithuanian, Polish and Russian. This also contained links to information about some specific health conditions.

The practice had provided staff with cultural awareness training and equality and diversity training. Staff we spoke with confirmed this.

The practice was situated on two floors of the building and there was a lift available to accommodate the needs of patients with limited mobility or for those with young children. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

Toilet facilities were available for all patients attending the practice including baby changing facilities on both floors of the building. These were kept locked but could be accessed by asking staff for a key.

A service was provided to vulnerable patients such as the homeless by registering them care of the practice's address. They also supported patients who misused drugs or alcohol by working with other specialist services.

Access to the service

The practice opened 8am to 8pm three days a week and 8am until 6.30pm two days a week. Appointments could be made in person, by telephone or online through the practice website. Detailed information was available to patients about appointments on the practice website and included how to arrange urgent appointments, home visits and urgent medical assistance when the practice was closed.

Standard appointments were for 10 minutes although longer appointments were available for patients who needed them such as patients with complex conditions. This included appointments with a named GP or nurse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There was a high rate of patients who did not attend their appointments. The practice was trying to address this and planned to introduce a text messaging service to make it easier for patients to cancel their appointments.

The practice had reviewed their data and found that patients aged 16-45 sought appointments twice as often as other national studies predicted. The practice also had a higher than average number of patients within this age category. In response the practice had increased GP and nursing staff numbers. They also tried to educate patients about using other services or accessing nursing appointments when relevant.

Some patients told us they were satisfied with the appointments system and could access an appointment on the same day. However, three patients told us they had difficulty accessing an appointment and had to wait for a week or longer when they felt their needs were more urgent. Parents with school aged children told us they had difficulty getting through on the telephone when the practice first opened in the mornings. When they called back after the school run, same day appointments were not always available. The practice held some appointments that were not released until 1pm that day. Patients we spoke with were not aware of this system.

Staff told us they asked patients for basic details when they called for an appointment so they could book them in with the most appropriate member of staff. If appointments were unavailable patients were asked to call back the next day and had to continue doing this until an appointment was available. Patients told us this was not always convenient. We found the practice used approximately half of their available appointments for pre-booked appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. It's complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager dealt with any complaints raised about the service and had an open door policy to encourage staff and patients to raise concerns. The practice leaflet included information for patients on how to raise concerns. This had been translated into some of the more common languages used by patients at the practice and was displayed on a noticeboard within the practice.

When we spoke with patients, one told us they had raised a concern and the practice manager had been very helpful and responsive. Two patients said they did not know how to raise a concern.

Concerns and complaints were taken very seriously and the practice used people's experiences to help improve the service for others. A record of the complaints showed that nine had been received since April 2014. These were considered by the manager and raised with staff so that learning could be implemented. For example a patient was unhappy about the arrangements for a specific appointment. This led to a review of access to appointments and outcomes were shared with the reception team as well as the patient participation group.

We reviewed the complaints log and found that the practice could improve the actions taken and lessons learned from complaints. The actions should be recorded in more detail and followed up in a timely way.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear plan and vision for the future. They believed that social intervention had a key role to play in the provision of high quality care for their patient population and were committed to improving outcomes for patients. They aimed to achieve this through empowering patients and working with them as equal partners in their care.

The practice was proactive in learning about the diverse needs of their registered patients. This ensured they could continue to provide a service that used resources wisely and responded to local needs. We spoke with nine members of staff who knew what their responsibilities were in relation to supporting practice values and were aware of the challenges faced by the practice in terms of delivering a responsive service.

Governance arrangements

The practice had a system in place to ensure that policies and procedures were regularly reviewed and accessible to staff electronically. Policies we looked at were up to date with the exception of the infection control policies. However, we found that some staff were not confident in being able to access these easily.

We found the leadership structure was not always clear although most staff knew who they reported to. The senior management team confirmed they had recently changed some of the lead roles and this may be why staff were uncertain about their responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance.(QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed overall lower performance levels than the national average scores. We found the practice reviewed their performance regularly and had some understanding about the reasons for poor scores. For example, a member of staff who spoke Polish was working with the practice nurses to try and improve attendance for cervical screening.

The practice had conducted several reviews of activities or services using their own data monitoring systems. We found they needed to develop and implement an audit plan to review key issues that were relevant to the health needs of their registered patients.

The practice had arrangements for identifying, recording and managing some key risks such as fire safety and legionella risks. However, we also found they did not have health and safety risk assessments in place such as the risk of staff experiencing violence and aggression.

Leadership, openness and transparency

The GP partners met together on a weekly basis. The practice aimed to hold separate monthly meetings for nurses, doctors and the reception team. These scheduled meetings had not taken place as frequently in recent months due to staff sickness and the introduction of the new information system. Some staff we spoke with confirmed they had meetings within their immediate team and were able to contribute to the agenda. A number of staff also reported to us that they felt the day to day communication within the practice team was not effective. We also heard that staff were not always fully informed of planned changes. All staff meetings took place on an annual basis.

We found that the process to share learning from any significant events, incidents or complaints could be strengthened to ensure that such learning was always shared with the staff team in a timely way.

The management team aimed to promote an open learning culture throughout the practice. When we spoke with staff we found that some attended meetings but they were unclear about the frequency or purpose of these. Minutes of meetings we asked for did not demonstrate that staff were involved in discussions about monitoring and improving outcomes for patients on a regular basis.

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

The practice last completed a patient survey during 2013-2014. Since that time they had continued to seek the views and opinions of their patient participation group (PPG) and other groups they interacted with through the practice's community centre and patient resource centre.

The PPG met approximately 10 times each year. We spoke with three representatives from the group who told us their

Are services well-led?

Good

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

experiences of being a patient at the practice.
They confirmed the practice manager and staff were very approachable and open to receiving feedback about the service. They also felt able to challenge and support improvements to the service. Examples of suggestions included ensuring patients understood the process for requesting repeat prescriptions and sick certificates so that appointments were used appropriately and ensuring the suggestions box and comments book were reviewed at each meeting. The meetings often included an update from the practice about local and national changes in the NHS and how this impacted upon their service.

Staff told us they felt able to give informal feedback to the management team although day to day communication was not very effective.

The practice had a whistleblowing policy which was available to all staff within the practice. Staff we spoke with were aware of the policy and knew how to raise concerns.

Management lead through learning and improvement

Staff received mandatory training and had further opportunities for professional development. There was a process in place to monitor the training attended. An annual review of training took place and this included the identification of training needs and sourcing new training. Staff accessed e-learning and this was at times, supplemented by team based training from local providers.

Records showed that staff received an annual appraisal where they were able to identify a personal development plan. Staff told us the practice was very supportive of training. We saw evidence that induction programmes were in place for clinical and non-clinical staff.

The practice completed reviews of significant events and complaints. Further development was needed to improve learning from these and ensuring that a systematic process was in place to share the learning with the wider staff team.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Review and strengthen the infection control procedures to ensure that; staff have clear and current guidelines to follow in practice, assurance is sought that the practice is cleaned effectively, staff have immunity against Hepatitis B. 12 (2) (h)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Improve the non-clinical health and safety risk assessments that are in place to ensure that potential risks for staff, patients and visitors to the practice are identified and managed. 17 (2) (b)