

Freuchen 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Freuchen Medical Centre is a GP practice which provides primary medical care including minor surgery to over 6000 patients in the Harlesden area of west London.

We carried out an announced comprehensive inspection on 22 October 2014. The inspection took place over one day and the inspection team comprised a CQC Lead Inspector and a GP.

The practice was rated as good in the area of responsive and requires improvement in the areas of safe, effective, caring and well-led. This gave an overall rating of requiring improvement.

Our key findings were as follows:

- safe systems were in place to monitor and manage individual patient care and safety
- care was planned and delivered effectively and patients underwent regular monitoring and medicines reviews

- patients reported that they felt listened to and involved in decision making.
- staff worked well with multidisciplinary teams to coordinate care for patients
- patients were generally satisfied with the ease of getting through on the phone and the opening hours at the practice.
- the practice was responsive to patient's needs and acted on feedback from them to improve the service

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

Importantly, the provider must:

- carry out infection control audits on a regular basis to ensure that infection prevention and control systems to prevent, detect and control the spread of a healthcare associated infection are effective

The provider should:

- share information on performance monitoring with staff in whole practice meetings

Summary of findings

- undertake a system of regular clinical and practice management audits and complete audit cycles to enable staff to regularly assess and monitor the quality of the services provided
- improve uptake rates for cervical screening and immunisations for under five year olds
- improve levels of patient satisfaction with respect to care and treatment
- carry out a legionella risk assessment

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?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. The practice had systems in place to identify, respond to and learn from patient safety issues. There were procedures for staff to follow to respond to concerns about safeguarding that included multidisciplinary information sharing and joint working. Staff recruitment processes protected patients from being cared for and treated by unsuitable staff. Equipment and machinery within the practice was regularly serviced and checked to make sure it was safe. Arrangements were in place to deal with and respond to emergencies and other major incidents.

There were infection prevention measures but no audits had been carried out to ensure that procedures were being followed to prevent and protect people from a healthcare-associated infection.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Staff followed and promoted evidence based best practice and worked effectively with other health and social care professionals to meet patient's needs. Systems were in place for staff induction, supervision and appraisal. The health and wellbeing of patients was promoted. Health checks were provided for new patients and advice and support was available to encourage patients to make healthy lifestyle choices.

Prescribing audits took place but there was no system to carry out other clinical and practice management audits. We saw evidence that some audits, such as the high energy formula milk audit, showed that targets set by the CCG were missed but there was little analysis to demonstrate why these targets were missed or how to improve results.

The practice had a consent policy in place and staff were aware of the issues of consent with vulnerable adults and others who may not have the capacity to consent.

Requires improvement



Are services caring?

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. All of the comments from patients were positive about the attitude and behaviour of staff. Patients described being listened to and supported to understand their diagnosis as well as being given

Requires improvement



Summary of findings

options about their care and treatment. However, the practice's own annual survey and the national patient survey indicated that over the last three years patients had become less satisfied with the levels of respect, consideration and concern shown by clinical and non-clinical staff at the practice.

Appropriate arrangements were in place to ensure patients gave informed consent to support/ treatment and any information that was to be shared. The practice had a chaperone service that was advertised in consulting and treatment rooms for patients.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice was responsive to patient's individual needs. Appropriate steps had been taken to ensure that the practice was accessible to patients with a range of needs including mobility issues and language barriers. Patient surveys and comments indicated that patients were generally satisfied with the ease of getting through on the phone and the opening hours at the practice. The practice had responded to results from patient surveys and rooms had been redecorated, new flooring laid in the waiting area and appointment times extended.

Patients with long term conditions were monitored and services such as phlebotomy and ECG were provided in-house to accommodate those patients. Complaints were taken seriously and responded to appropriately.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. GP partners and staff expressed their vision and strategy as providing a high quality service with good access for patients. There was a governance lead and clinical and non-clinical staff were clear on their roles and responsibilities in key areas such as safeguarding and infection control. The leaders were visible and approachable and staff reported a supportive environment where they were able to voice their concerns. The practice held regular patient surveys and acted on feedback from its patients and staff.

Audits had been carried out but there was not a systematic programme of clinical and practice audits. Lessons were learned and shared informally and there were regular whole practice meetings but we did not find evidence to show that practice performance was reviewed and discussed with staff at these meetings. Performance was reviewed externally through CCG peer review and this had led to improvements in the service.

Requires improvement



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

The practice is rated as requires improvement for the care of older people. Older people had same day access to a doctor and telephone consultations were available. There were 240 older patients and they had been notified of their named GP. The practice provided care planning and worked with district nurses and other healthcare professionals to provide an integrated care plan for those 120 patients in the top 2% at high risk of unplanned admissions to hospital. Patients were invited to the surgery and involved in devising their care plan. Home visits were made to those patients who were bedbound, to arrange care plans and those recently discharged from hospital were contacted to follow up their care. Emergency bypass numbers were given to emergency services so that they could contact the practice without delay should they be dealing with an older patient.

GPs opportunistically screened patients for long term conditions such as arthritis and dementia. They made any necessary referrals to a memory clinic for those at risk of dementia. Flu, shingles and pneumococcal vaccinations were offered. Monthly meetings were held with community nurses and quarterly meeting for patients who were on end of life care plans.

There was a lead clinician responsible for safeguarding vulnerable adults and staff were able to recognise signs of abuse in older people and we were informed of incidences when these concerns had been escalated to the appropriate authorities.

The provider was rated as requires improvement for safe, effective, caring and well-led. The concerns that led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



People with long term conditions

The provider is rated as requires improvement for the care of people with long-term conditions. One third of the practice population (2500) had long term conditions and the practice had systems in place to support this group of patients. There were nurse-led clinics for asthma, diabetes, heart disease and hypertension. Hypertension formed the largest group and these patients were screened for diabetes. The lead GP for diabetes told us that an audit on statin uptake in patients with diabetes had shown improvement.

Multidisciplinary team meetings with other community healthcare professionals were held throughout the year and doctors shared care plans to facilitate coordinated care for patients with long term

Requires improvement



Summary of findings

conditions to prevent admissions to hospital. There were regular meetings/joint visits with palliative care nurses for those on the palliative care register. A dietician, counsellor and community nurses held clinics at the practice to provide support and advice. The practice was planning to introduce an obesity clinic in the future. Phlebotomy, 24 hour blood pressure and electrocardiogram (ECG) monitoring services were available and patients told us they found this convenient in helping them to manage their condition.

QOF (Quality and outcomes framework) registers were reviewed each month and patients contacted to attend for reviews of if there were concerns. Those with mobile phones were sent a text message inviting them to the surgery. Flu and pneumococcal vaccinations were offered to patients with long term conditions and the practice was performing well with 56% patients in the defined clinical risk groups up to the age of 65, having received the flu vaccine.

The provider was rated as requires improvement for safe, effective, caring and well-led. The concerns that led to these ratings apply to everyone using the practice, including this population group.

Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. Child health surveillance clinics were held to monitor child development and administer vaccination and immunisations for new born babies and young children. In the last year 90% of under two year olds had been immunised although the figure was slightly lower for children under five years. Clinical staff worked with the health visitor and district nursing staff to provide coordination of care. Antenatal care clinics with a midwife were provided at the practice.

The practice offered chlamydia screening for patients over 15 years old and cervical screening for women. Cervical uptake rates were 71% and lower than the CCG average. Doctors told us they were trying to improve this uptake rate by reminding patients of their appointments with text and telephone calls.

The GP child safeguarding lead shared information with multidisciplinary teams to improve the safety of vulnerable children. Staff were aware of child protection safeguarding procedures and informed appropriate authorities when necessary. They were familiar with the Gillick competencies and staff told us they would assess a patient such as a teenager requesting contraception and document it in their records.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working age people, including those recently retired and students. The practice provided extended opening hours on two evenings a week until 8pm to accommodate the needs of those working during the day. In response to patient requests the practice had introduced a pilot of early morning appointments one day per week because a number of patients worked on night shift and wanted to access the practice after they left work. It was also convenient for early morning commuters. An online appointment booking service was available.

Health checks were offered for 40-74 year olds and three staff had been trained to advise patients on smoking cessation. Three years ago the practice had the highest cessation rate in the locality but this had now fallen to 70% which was below the rest of the CCG area. Staff were working to improve this figure again. New patients were offered a health check with the health care assistant. This included checking their weight and blood pressure whilst also giving them an opportunity to discuss lifestyle factors affecting their health and wellbeing such as smoking or drinking alcohol.

The provider was rated as requires improvement for safe, effective, caring and well-led. The concerns that led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



People whose circumstances may make them vulnerable

The provider is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice registered different vulnerable groups such as homeless people and patients were able to use the practice address to receive healthcare communication. Staff told us they provided patients within this group with initial care and sometimes referred them after that to a neighbouring practice within the Harness group which specialised in caring for homeless patients. Patients who were not registered at the practice were able to access emergency medical care and contraception.

Other groups such as street sex workers were able to register with the practice and doctors signposted them where necessary for sexual health screening at a genito-urinary clinic in the locality. The practice held a register for those patients with a learning disability.

One GP was the lead in the care of those patients who misused drugs and alcohol and worked with community drug and alcohol services. Carers, for example, for those with a learning disability were

Requires improvement



Summary of findings

registered on the database so that all staff had access to that information when a patient attended the practice. Staff were aware of the principles of the Mental Capacity Act 2005 and understood the need to obtain patient consent.

The provider was rated as requires improvement for safe, effective, caring and well-led. The concerns that led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

The provider is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia). The practice had over 100 patients with poor mental health and they had annual reviews and health checks which included a physical check. Doctors worked closely with local services and referred patients to assessment and brief treatment (ABT) teams and improving access to psychological therapies (IAPT) to be assessed and for counselling.

Patients were given an emergency psychiatric telephone number to contact when experiencing a mental health crisis. Patients at risk of dementia were identified and referred to a memory clinic where appropriate.

The provider was rated as requires improvement for safe, effective, caring and well-led. The concerns that led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



Summary of findings

What people who use the service say

We spoke to two patients who were members of the Patient Participation Group (PPG) and they were complimentary about the staff and said they were treated with respect and confidentiality. They told us they received good care and treatment and both clinical and reception staff took time to explain things to them. 30 patients completed comment cards which were left in the reception area and comments were overwhelmingly positive about the treatment they received at the practice. There were a number of comments about the difficulty in getting an appointment and having to wait a long time before seeing a doctor once at the practice.

Before our visit we reviewed the results of an independent national GP survey of the practice carried out in 2013 which found that the practice was rated as “among the worst” for patients describing their overall experience as “good” or “very good”. The practice’s own annual survey indicated that over the last three years patients had become less satisfied with the levels of respect, consideration and concern shown by clinical and non-clinical staff.

Areas for improvement

Action the service **MUST** take to improve

- carry out infection control audits on a regular basis to ensure that infection prevention and control procedures are effective and being followed

Action the service **SHOULD** take to improve

- share information on performance monitoring with staff in whole practice meetings

- undertake a system of regular clinical and practice management audits and complete audit cycles to enable staff to regularly assess and monitor the quality of the services provided
- improve uptake rates for cervical screening and immunisations for under five year olds
- improve levels of patient satisfaction with respect to care and treatment
- carry out a legionella risk assessment

Freuchen Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Freuchen Medical Centre

Freuchen Medical Centre is a GP practice which provides primary medical care to over 6000 patients in the Harlesden area of west London. It provides a number of services such as minor surgery and phlebotomy as well as nurse-led clinics. It is situated in an ethnically diverse inner city area with high levels of deprivation. One third of the patients in the practice have long term conditions such as heart disease and diabetes and there are a high number of patients with poor mental health. There were a higher than average number of patients aged between 20 and 49 years with a lower number of older patients above 55 years old.

There are four GP partners (two male who are part-time and two female), one long term locum GP, a full time female practice nurse and health care assistant (HCA), practice manager, assistant practice manager and nine reception/administration staff. The locum GP provides cover during periods of leave and sickness.

GPs have opted out of providing out-of-hours services to their own patients and employ the services of an out of hours GP provider to fulfil this role. Information within the practice and in the practice leaflet advertises telephone

contact details for patients to call if they have medical problems after the surgery is closed or at weekends. The practice holds a general medical services contract (GMS) with NHS England.

The practice does not have a website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

Before the inspection reviewed a range of information we hold about the practice. We talked to Brent Clinical Commissioning Group (CCG) and one health professional in the community who dealt with patients from the practice. During our visit we spoke with a range of staff (four GP partners, practice nurse, HCA, practice manager, assistant practice manager and two administration/reception staff. We spoke with two patients who were members of the Patient Participation Group (PPG). We reviewed treatment

Detailed findings

records of patients and looked at the practice's policies, procedures and audits. We reviewed management and staff files and 30 comment cards which patients had posted on the reception desk.

We carried out an announced visit on 22 October 2014. During our visit we spoke with a range of staff (four GP partners, practice nurse, HCA, practice manager, assistant practice manager and two administration/reception staff. We spoke with two patients who were members of the Patient Participation Group (PPG). We spoke with a district nurse who works with the practice in caring for patients in the community. We reviewed treatment records of patients. We looked at the practice's policies, procedures and audits. We reviewed management and staff files. 30 patients wrote comments on the cards which we reviewed.

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)

Are services safe?

Our findings

Safe track record

The practice had safe systems in place for reporting and recording incidents. Staff understood their role and the processes for reporting incidents that affected patient's safety. They told us that when an incident occurred they often discussed it straightaway with a GP or manager before completing the report form. We were told by one GP that these incidents were then discussed at a separate Significant Event Analysis (SEA) meeting or practice meeting if appropriate so that staff were kept informed. We saw examples of significant events which had been recorded on a form and included details on discussion and learning points for staff, as well as review dates. We noted that different staff had completed these forms which were known as Significant Event Analysis (SEA) forms. These incidents were then recorded on a significant events log. We saw evidence that significant event review meetings had been held where events had been discussed.

National patient safety alerts were disseminated to staff electronically by a designated staff member.

Learning and improvement from safety incidents

We reviewed three SEA forms. One event involved the vaccination storage fridge door being left open and staff noticed that and the fridge thermometer appeared to show the fridge was not operating at the correct temperature. They were unable to reset the temperature. This event led to the vaccines in the fridge being disposed of and staff reminded to close the fridge door after use and to have the refrigerator company's details to hand. We spoke to the nurse and she confirmed that they had the refrigerator company contact details in a folder.

Reliable safety systems and processes including safeguarding

Staff were able to recognise signs of abuse in older patients and knew how to escalate and refer those concerns.

Safeguarding policies for both children and adults were in place and two GPs were the safeguarding leads in each area. Each consultation room had a flowchart detailing contact details and the referral process to the local authority should a clinician have concerns about a child or vulnerable adult. Doctors told us they liaised with the lead GP for safeguarding in the local area and one GP described one referral they had made of a vulnerable adult. They had

referred them to both the local authority and the community health mental team (CMHT) for a full mental capacity assessment. Non-clinical staff were able to describe the different forms of abuse and how they would report a concern. They said they would initially speak to the lead GP and then refer to the local authority if appropriate. Alerts were put on patient records on the practice database to alert all staff to child and vulnerable adult safeguarding concerns.

All GPs and the practice nurse had training in child protection to Level 3 as well as vulnerable adults training which was in line with national safeguarding guidance. We saw evidence that other staff had undergone up to date safeguarding training or were booked to attend update safeguarding courses within the next two months.

There was a chaperone policy and notices regarding chaperoning on the wall in the patient waiting area and in consulting and treatment rooms. They explained that patients could ask for a chaperone if they wanted one. Clinical staff told us they asked patients if they wanted a chaperone present when for example patients were undergoing an intimate examination, and noted this in patient records. Reception/administration staff had criminal records checks (known as Disclosure and Barring Service) checks and understood their role. They told us of instances when they had acted as chaperones for patients. We saw an anonymised patient record which noted that a chaperone had been offered, but declined by the patient.

Medicines management

The practice had systems for reviewing repeat prescriptions using the database to identify when patients were in need of a review. Quality and Outcomes Framework (QOF) data showed that the practice was performing well in carrying out medicines reviews on patients who were prescribed four or more repeat medicines as well as those patients on repeat medicines.

There were protocols for the management of medicines. We saw evidence of low prescribing rates and low use of non-steroidal anti-inflammatory drugs (NSAIDs) which was in line with local and national prescribing guidelines.

Patients we spoke to said it was easy to get a repeat prescription and it was ready within 48 hours. There was no online facility to request repeat prescriptions for patients although they could request them by telephone to collect from a chemist.

Are services safe?

The practice had a secure system for controlling and recording electronic prescription and prescription pad movement which was important to ensure prescriptions were accounted for and could not be misused or stolen.

The practice had a policy on the storage and checking of vaccinations. There was one fridge which was used for the storage of vaccines and which was locked. We saw records of fridge temperatures which were taken twice a day using the in-built fridge thermometer.

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.

Cleanliness and infection control

The practice had an infection control policy which included contact details of the community infection control team. There were procedures on body fluid spillage, environmental cleaning and clinical waste disposal. All staff members we spoke to were aware of the policy and that the lead on infection control was the practice nurse. We checked staff files and found that staff had received or were booked to undertake updated infection control training.

The practice was visibly clean and tidy throughout. A cleaner, who had received infection control training, attended every working day and followed a cleaning schedule which included daily, weekly and monthly tasks. However, no infection control audits had been carried out to check that procedures were being followed to prevent and protect people from a healthcare-associated infection.

Appropriate personal protective equipment such as gloves and aprons were accessible to staff in consulting and treatment rooms as well as supplies of soap and sanitiser for handwashing. We also saw instructions above the sinks in these rooms to remind staff about the correct handwashing techniques. Sharps bins were safely located and clinical waste was appropriately stored and collected.

We saw evidence that clinical staff had hepatitis B immunity blood test checks in order to minimise the risk of spreading infections.

A legionella risk assessment had not been carried out.

Equipment

PAT (portable appliance tests) testing had been carried out on electrical equipment throughout the building to ensure they were electrically safe. We saw a gas safety certificate which showed that the heating system had been checked this year and was safe.

Arrangements were in place for checking machinery and equipment within the practice. We saw test and calibration records for equipment such as spirometers and blood pressure machines, which demonstrated they were regularly serviced and calibrated.

Staffing and recruitment

Most of the staff had worked at the practice for a number of years. The practice did not use the services of a locum GP agency but employed a long term locum GP to cover periods of leave and sickness. Non clinical staff covered for one another during staff shortages and busy periods. It was a busy practice but staff felt there were enough staff to cover the work. Some staff members were multiskilled and had trained as smoking advisors. One receptionist had trained and worked part of the time as a healthcare assistant and phlebotomist within the practice.

The practice had induction checklists for each area of work and one new staff member told us they had completed the induction checklist before they started work. The nurse told us they completed a practice nurse's course.

Effective recruitment and selection processes were carried out. Staff told us they completed an application form and attended for an interview before being employed. We checked staff files and found that criminal records checks were undertaken before staff started to work at the practice. Other recruitment checks included checks with appropriate professional bodies, identity, right to work in the UK and previous employer references.

Monitoring safety and responding to risk

The practice monitored safety and responded to risk. A building risk assessment had been carried out in September 2014. Issues that had been identified in the risk assessment, such as broken electrical sockets, had been repaired or been scheduled to be repaired.

When incidents and risks were identified, they were discussed and measures put in place to prevent a recurrence. An incident with a patient who threatened staff

Are services safe?

was discussed and staff safety protocols reviewed. This had resulted in a more robust system for staff to immediately alert others via the computer should they find themselves in an emergency situation.

The practice had carried out a health and safety risk assessment which detailed risks to staff and patients such as slipping and tripping on cables or objects left on the floor and actions taken to minimise those risks. This was reviewed every six months.

The practice had a comprehensive business continuity plan which detailed how they would deal with emergencies such as loss of electrical power, which might interrupt the smooth running of the service. Paper copies of the plan were held separately in the event of a loss of electrical power so the staff would still be able to contact essential people. There was a list of contact details of staff and service providers such as the telephone service provider.

Arrangements to deal with emergencies and major incidents

Staff we spoke with told us they knew where the emergency equipment was located and what to do in the event of a medical emergency. The practice had an emergency medical kit, oxygen cylinder, defibrillator and pulse oximeter which were within date and we saw records that they were regularly checked by the practice nurse. We saw evidence that staff underwent annual mandatory training in basic life support (BLS) which included training in the use of the defibrillator. An anaphylaxis kit was within its use by date, accessible and available for use.

Fire Safety drills and checks of the alarm system and fire safety equipment were regularly carried out within the building. One staff member was a nominated fire marshal. We saw records of two fire drills which had been carried out in 2014.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

When planning patient's care and treatment GPs used a variety of guidance such as National Institute for Health and Care Excellence (NICE) and Brent local antibiotic prescribing guidance to promote best practice in areas such as end of life care and prescribing. They told us how they accessed guidance during consultations and discussed new updates and changes at their weekly clinical meetings. They also received update information by email and these were discussed both informally and at practice meetings. Doctors undertook minor surgical procedures in line with their registration and NICE guidance.

The GPs regularly attended Clinical Commissioning Group (CCG) locality meetings where local practices met to discuss current clinical and organisational performance and issues. The performance of the practice was comparable with other local practices.

Management, monitoring and improving outcomes for people

We saw that data sources (medicines management information, safety alerts or as a result of Quality and Outcomes Framework (QOF) performance) were used to gather information about patient experience, quality and performance. These had been used by the CCG and the practice to identify areas that required improvement and to develop action plans. Some of these areas related to prescribing matters, patient attendance at Accident and Emergency and smoking cessation rates.

The practice carried out prescribing audits and used the results to improve outcomes for patients. We saw evidence to show that the practice was performing well within the CCG area with respect to rate of antibiotic prescribing and percentage of ibuprofen and naproxen with respect to all non-steroidal anti-inflammatory drugs (NSAIDs). However, there was no system in place to carry out other clinical and practice management audits and complete audit cycles to enable staff to regularly assess and monitor the quality of the services provided. We saw evidence that some audits, such as the high energy formula milk audit, showed that targets set by the CCG were missed but there was little analysis to demonstrate why these targets were missed or how to improve results.

Referral rates were discussed at CCG meetings and the referral rate for the practice was similar to other practices within the area.

Effective staffing

The practice had an induction process for clinical and non-clinical staff. This included shadowing experienced staff, familiarising staff with protocols and completing an induction checklist. Training records for staff showed they had completed training in areas such as safeguarding children and adults, infection control and equality and diversity. We saw evidence of annual appraisals which included objectives and the opportunity to identify areas for development. Although there was no formal documented supervision, staff told us they received regular supervision and peer review.

Doctors had been revalidated and had personal development plans resulting from their appraisals. The practice nurse was registered and was due for reregistration in November 2014. Regular clinical and practice meetings were held so that information and updates were conveyed to all staff. Most staff we spoke to felt supported and able to develop their skills and professional training. One member of staff told us the GP partners had recently approved them to carry out further training. All staff received annual appraisals and the nurse was appraised by one of the GP partners.

Working with colleagues and other services

The practice had established relationships and worked effectively with other services such as the community nursing team. We talked with healthcare professionals and they spoke positively of how the practice staff worked closely with them to ensure that patient needs were met. They had regular multidisciplinary meetings and the district nurse said the practice listened to their concerns and kept them informed of updates concerning patients. They said they found it easy to contact the practice and they were immediately able to speak with the doctor. They also had doctor's mobile numbers to enable them to speak to them urgently about a patient.

The practice had systems in place for managing blood and other test results. Results came into an electronic mailbox every day and along with faxes were screened by a trained member of staff called a summariser then forwarded to appropriate GPs inboxes. Results were downloaded onto the patient records on the computer database. Outpatient

Are services effective?

(for example, treatment is effective)

letters and hospital discharge summaries were scanned and attached to patient records on the computer database. The GPs reviewed them and contacted the patients to ask them to attend the practice if necessary.

Care for patients was provided by an out of hours provider. Reports for patients seen out of hours were received every morning so that patient records could be updated as soon as possible. They were allocated to GPs for review on the day they arrived.

Information sharing

Clinical staff told us they had frequent engagement and communication with other healthcare professionals. They attended regular multidisciplinary team meetings, as part of the north west London integrated care programme, and which included geriatricians and psychiatrists. The aim was to coordinate care for 120 patients in the top 2% of being at risk of being admitted to hospital and those with complex needs. Home visits to complete care plans were arranged for those patients who were housebound.

Doctors and the nurse had regular meetings and went on joint visits when appropriate, with the community nurses for patients on the end of life care register and palliative care nurses for those on the palliative care register. They had regular meetings with the health visitor. We saw evidence of meetings where concerns about housebound patients and those with long term conditions were discussed with follow up actions where necessary.

Staff gave us examples of how they worked with the different patient groups and had contacts with other specialist services. They referred patients with depression and mental health needs to assessment and brief treatment (ABT) teams and improving access to psychological therapies (IAPT) for counselling.

Consent to care and treatment

The practice had a consent policy which set out the types of consent and how to obtain and record it. Written consent was obtained for procedures such as minor operations or coil fitting, otherwise it was verbal or implied and this was recorded in patient notes. We saw an anonymised record where consent was documented.

Clinical staff were familiar with the principles of the Mental Capacity Act 2005 and the Children Act 2004 and

demonstrated they understood issues around informed consent. They were able to explain how they would assess patients for capacity and obtain consent. The nurse gave us an example of how they had explained procedures through pictures for a vulnerable adult patient with a learning disability, to ensure they understood.

Staff understood the Gillick competencies and told us they would assess a patient such as a teenager requesting contraception and document it in their records.

Health promotion and prevention

All new patients were offered a health check with the health care assistant and this included checking their weight and blood pressure whilst also giving them an opportunity to discuss lifestyle factors affecting their health and wellbeing such as smoking or drinking alcohol.

Information on a range of topics and health promotion leaflets were available in the waiting area. The practice had trained three members of staff to become smoking cessation advisors. Once smokers had been identified in the patient population they were offered an initial meeting then further meetings as required. Three years ago the practice had the highest cessation rate in Brent CCG but this had now fallen to 70% which was below the rest of the CCG area. Staff told us they were working to improve this figure again.

Systems were in place to ensure that children received their childhood vaccinations and in the last year 90% of under 2 year olds had been immunised. The figure was slightly lower for children under 5 years and staff told us that although they reminded patients by text and with phone calls of their appointments, patients often changed their phone numbers without notifying the practice. Patients over the age of 75 and other vulnerable groups were offered flu, shingles and pneumococcal vaccinations. The cervical screening rate uptake was 71% which was below the CCG average.

The practice ran in-house midwife clinics as well as dedicated mother and baby clinics. They used these clinics to provide health and wellbeing advice opportunistically to patients. Chlamydia screening was offered to patients over the age of 15.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2014 national patient survey found that the 79% patients described their overall experience as “good” or “very good.” Patient levels of satisfaction with the nurses and doctors treating them with care and concern was 86% and 75% respectively which was slightly below average. Freuchen Medical Centre’s own annual survey indicated that over the last three years patients had become less satisfied with the levels of respect, consideration and concern shown by clinical and non-clinical staff at the practice. Practice staff said they were trying to improve this figure but it was a very busy practice with a highly mobile patient list. The vast majority of comment cards completed by 30 patients reported very positive experiences with regard to care and respect.

During the course of our inspection we observed staff speaking to patients respectfully even though they were working in a busy environment. We spoke with two members of the patient participation group (PPG) on the day of our visit and they told us they felt they were treated with dignity and respect. One told us that they had seen reception staff fast-track a patient who seemed to be ill so that they were not kept waiting, which demonstrated empathy and consideration of the needs of the patient. The practice had a chaperone service that was advertised in consulting and treatment rooms for patients who may want to have a trained member of staff of the same gender present for examinations.

Patient confidentiality was taken seriously within the practice and two members of staff were trained and nominated Caldicott guardians to protect the confidentiality of patient information and enable appropriate information –sharing. In treatment and consulting rooms, clinicians told us that privacy curtains and window blinds were used to preserve privacy for patients. Reception staff told us that if a patient wanted to speak with them confidentially, they would take them to a room next to the reception to do so.

Care planning and involvement in decisions about care and treatment

Clinical staff told us they took all reasonable steps to enable patients to make decisions about their own care and treatment wherever possible. They told us they accessed a medical website from which they could download explanatory leaflets and told patients of websites they could access so they could understand their diagnosis. They sometimes drew diagrams to support patients to understand their diagnosis. Data from the national patient survey showed that 71% of practice respondents said the GP involved them in care decisions.

Patients described being listened to and supported to understand their diagnosis as well as being given options about their care and treatment. The GP and nurse said they always involved patients in their own treatment and care. Staff understood issues around the mental capacity of patients. They were able to demonstrate that they had taken appropriate action to explore concerns about individual patients and their ability to understand the medical conditions affecting them, to make informed decisions.

There were protocols in place to ensure patients consented to treatment and that information was only shared with individuals on behalf of patients after consent was received. The practice had a carer’s register and carers were able to contact a doctor to discuss the care of the patient they were responsible for within these confidentiality constraints.

Patient/carers support to cope emotionally with care and treatment

Relatives and carers were given consultation time if they wanted it following a bereavement. Staff said they may signpost the bereaved patient for further support should they want it. There was information in the waiting area signposting patients to support groups for bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patient access areas were situated on the ground and first floor. There was no lift and doctors used the ground floor consulting rooms for those patients with poor mobility who were unable to climb the stairs. Treatment rooms, mother and baby clinics and midwifery services were all held on the ground floor and there was also a disabled access toilet. The entrance and waiting area were spacious enough to accommodate people with pushchairs and wheelchairs.

The practice met the needs of different groups of patients. Information on interpreting services was advertised in the waiting area and on the practice leaflet. Reception staff told us that they could access interpreting services promptly if needed. Longer appointment times were given if an interpreter was present to allow enough time for the consultation and interpretation of the conversation. Proactive care planning was in place for patients at high risk of unplanned hospital admission and a district nurse we spoke to told us that they and other healthcare professionals met regularly with clinical staff to reduce this risk.

Patients with long term conditions were monitored and all those in need of a review were contacted by telephone or sent a text message inviting them to attend the surgery. The practice had a large group of patients (700) with hypertension and ran in-house ECG (electrocardiogram) and 24 hours blood pressure monitoring services. There was an in-house phlebotomy (blood test) service and a community dietician also attended the practice once a month. Patients experiencing poor mental health were given a phone number for an emergency psychiatric service when appropriate so that they could access medical help in urgent situations.

The practice had a long-standing PPG which met three to four times a year and they consulted with them before running annual patient surveys to find out the priority areas for patients. Two years ago a patient survey had indicated patients wanted the practice to be redecorated and to have extended surgery times. The practice had responded and rooms had been redecorated and new flooring laid in the waiting area. Late evening appointments up to 8pm were introduced on two days.

Tackling inequity and promoting equality

The service acted to remove barriers with patients who may find it difficult to access the service. Homeless patients who attended the practice were able to register with them and use the surgery as their address. Home visits were arranged for housebound patients so that care plans could be put in place and these patients were included in integrated care planning. Older patients were screened for dementia opportunistically when they attended the practice.

A pilot extended appointment time had recently been initiated to offer early morning appointments from 7.30am one day per week, because a number of patients worked on night shift and wanted to access the practice after they left work. It was also convenient for early morning commuters. The pilot had only been running for a few weeks so it was too early to analyse the results. A midwife attended every week to provide antenatal care for pregnant women and there was a 'well baby' clinic for child health surveillance.

Staff had undertaken training courses in equalities and diversity and one member of staff told us they felt it had improved their understanding and ability to deal sensitively with patients.

Access to the service

Appointments were available from 8.30am to 6.30pm on Mondays and Fridays. A half day operated on Wednesdays with appointments from 8.30am to 1pm. Extended hours operated on Tuesday and Thursday evenings with the practice open until 8pm. Patients could make appointments by telephone, in person or online. The practice also operated a triage telephone service with a duty doctor. One patient confirmed they had a telephone consultation with a doctor. Patients could be seen for urgent appointments on the day although for routine appointments they may have to wait up to two weeks and may not see a doctor of their choice.

Information was available to patients about appointments in the waiting area and in the practice leaflet. There was no practice website.

Appointments for medical emergencies were given on the day and home visits were available for those who were not able to attend the practice. Older patients and those with long term conditions were offered home visits where necessary. Longer appointments were available for those

Are services responsive to people's needs?

(for example, to feedback?)

attending with an interpreter or with complex needs. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed and information on the out of hours service was provided in the leaflet and in the waiting area.

Patient surveys and comments indicated that patients were generally satisfied with the ease of getting through on the phone and the opening hours at the practice.

Listening and learning from concerns and complaints

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

The complaints process was referred to in the practice leaflet although it was not clear who the patient should contact in the first instance to make a complaint as the designated person was different to that in the complaints policy. We reviewed the records of the last two years of complaints and found that there was a documented audit trail for all complaints that were made. This showed the concern raised, the investigation undertaken and the outcomes for the complainant and the practice. The practice manager said they or a doctor would try to speak to the patient making the complaint initially if that was appropriate to see if they could resolve the matter promptly. Staff were clear about how complaints were managed.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

Freuchen Medical Centre was one of the founding members of a local network of GP practices (known as Harness Care Cooperative Ltd) with a shared vision to deliver improved primary care services to their local population. They aimed to do this by sharing resources where possible in areas such as workforce planning and providing an “episodic care hub” for patients in need of urgent care.

GP partners expressed their vision and strategy as providing a high quality service with good access for patients within this network. They were aware of potential risks to the quality of care they provided because of an increasingly diverse practice population in a highly deprived area. Their objectives for the future were to adapt to the needs of the patients and build up the number of services provided. They intended to start an obesity clinic and expand surgery times. The premises had recently undergone a partial refurbishment which had provided further rooms.

Staff were able to describe similar values and felt there was a good relationship and communication between all of the staff and between staff and patients.

Governance arrangements

There was a governance lead GP and when we asked practice staff about governance arrangements they were clear about who was responsible for each area. Staff had roles and responsibilities that included taking a lead role in key areas in the practice such as safeguarding children and vulnerable adults, infection prevention and control, health and safety and areas of clinical expertise. They demonstrated they had the knowledge and experience to fulfil these roles in order to provide care, support and treatment for patients.

The practice had carried out audits, such as prescribing audits, which were contractual obligations. Other audits had been carried out, such as that of patients at high risk of unplanned admissions, but there was not a systematic programme of clinical and practice audits. We saw evidence that improvements to performance had been made as a result of some audits but others did not demonstrate monitoring and review with a conclusion to identify what actions had been taken.

Leadership, openness and transparency

The practice was managed by four GP partners, practice manager and assistant practice manager. Two GPs worked part-time including the senior GP partner who had worked at the practice for over 25 years and now worked part-time. The leaders were visible and approachable and staff reported a supportive environment where they were able to voice their concerns. There were regular whole practice meetings and on occasions the GPs supported a lunch meeting for the staff. Staff were aware of the whistleblowing protocol to use should they have concerns about other staff and how the practice was run.

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

The practice did not carry out formal staff surveys. Most staff felt their views were listened to and acted on if necessary. There had been concern about staff security following some incidents and procedures had been improved so that staff responded immediately when alerted via the computer system.

The practice had a long-standing PPG which met regularly throughout the year. We spoke to two members of the group who told us they were encouraged to make suggestion about improving the practice and felt they were listened to. The PPG was invited to put forward priority areas for inclusion into the annual patient survey. Survey forms were left at the reception desk and those returned were analysed and an action plan drawn up. One suggestion which was implemented was to set up triage telephone consultations for patients who telephoned in the morning and the doctor rang them back.

Management lead through learning and improvement

Annual individual staff appraisals took place that included personal development for the year ahead. There were management systems in place which enabled learning and supported staff to improve their practice. GPs and the practice nurse received appropriate appraisals and peer support arrangements were also in place. We spoke to newly recruited staff who told us they had undertaken a formal period of induction.

We reviewed the minutes of whole practice meetings held in 2014 and did not find evidence to show that practice performance was reviewed and discussed at these meetings. However, staff told us the practice had recently started to hold meetings to discuss significant events and

Are services well-led?

Requires improvement



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

we saw evidence of these discussions. Lessons were shared informally day to day and doctors had regular clinical

meetings which were minuted, to discuss and learn from patient cases. Performance was reviewed externally through CCG peer review and this had led to improvements in the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risk of exposure to a healthcare associated infection because there was not an effective system to audit and check if infection control measures, were operating correctly. Regulation 12(2)(h)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	