Princess Street Group Practice

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Princess Street Group Practice on 22 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. The practice was good for providing services for the six population groups we report on: 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 and people experiencing poor mental health (including people with dementia).

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

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

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw a number of areas of outstanding practice:

- The practice was particularly effective in supporting patients with long term conditions. Data from the Southwark population health services showed that the practice had achieved double its target for the 2014 /15 year in collaborative care planning for patients with certain long term conditions. The practice was a high QOF achiever, their performance for clinical domain indicator groups was better than the local and national averages for all diseases reported. The practice performance was 100% for all but two groups.
- The practice is near Southbank University and actively engaged with students at Fresher's week with registration opportunities and sexual health screening information. They also worked closely with the health advisors based at the university.

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

The provider should

- Ensure infection prevention and control policies and procedures are kept under review and up to date.
- Ensure portable appliance testing (PAT) and fire safety checks are completed in line with the practice's policy

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Risks to patients who used services were assessed, the systems and processes to address the identified risks.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice was a high QOF achiever, their performance for clinical domain indicator groups was better than the local and national averages for all diseases reported. The practice performance was 100% for all but two groups.

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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Summary of findings

Most patients that provided feedback to us were satisfied with the appointments system and said it was easy to use. A few patients we spoke with and some that completed CQC comments cards were not entirely satisfied with the appointments system, and highlighted they experienced long delays getting appointments, and long waits to be seen for their appointments.

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

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice participated in the delivery of a range of services and incentives designed by the local clinical commissioning group (CCG). For example, they case managed housebound patients and elderly patients. In addition, they delivered the local CCG elderly care pathway, and carried out dementia screening. Data showed that the practice had an identification rate of new cases of dementia that was higher than the national average.

The practice participated in the delivery of the elderly care pathway during the two years prior to our inspection. The pathway involved practice based holistic health assessments, home based health assessments and case management. During the 2013 / 14 year, they carried out 72 assessments in the practice and 19 in patients' homes. During the 2014 /15 year, the figures were 89 assessments and 55 assessments respectively. During the 2014 / 15 year the practice also case managed 33 patients.

The practice had been involved in a local integrated care project with secondary care, community care and primary care (SLIC) targeted at older adults and housebound patients. Older people were invited for a holistic health assessment at home or in practice and their nurse practitioner provided active case management. The nurse practitioner also attended monthly multidisciplinary meetings to discuss patients with an elderly care consultant, the community nursing team and social services.

All patients over the age of 75 had a named GP. The practice had been working for the unplanned admissions direct enhanced service (DES), documenting and discussing shared care plans with those on the register which includes significant numbers of older people. The practice worked closely with their local district nurses and held monthly meetings with them to discuss patients and issues.

Summary of findings

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

The practice offered health management clinics for patients with long term conditions (LTC). In response to patient feedback, the practice had streamlined their LTC reviews into one "Health Management Clinic", where patients were seen for an annual review of their condition. These included care planning and self-management support, as well as preventative care planning.

Patients with long term conditions had a named GP. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Data from the Southwark population health services showed that the practice had exceeded its target for the 2014 /15 year in collaborative care planning for patients with certain long term conditions: diabetes, hypertension and chronic obstructive pulmonary disease (COPD). The year's target was 337 patients, but the practice had completed collaborative care planning for 748 patients.

The clinical team met weekly to discuss all LTC cases booked in the week ahead to agree management plans. They told us that this provided excellent learning for the whole team and helped them maintain their clinical skills.

The practice held twice yearly virtual clinics for COPD and diabetes, with consultants and community teams to discuss cases and clinical issues. They also liaised closely with the Heart Failure Team and were planning to start a virtual clinic for this condition in the near future as well.

The practice clinical team met with the palliative care team every three months to discuss current cases, potential referrals, and recent deaths to share learning.

The practice team told us that in the two years preceding our inspection they had carried out some focussed work to increase their detection of patients with LTCs. As a result their diabetes, hypertension and dementia registers had grown steadily. They had screened significantly more patients for dementia than the national average. There had also been significant work in identifying patients at high risk of developing diabetes, and had created a register of these patients, all of whom were offered annual reviews.

Summary of findings

There has been a borough wide (Lambeth/Southwark) diabetes project over the last three years and one of the GPs has been a clinical lead in this, helping to driving local change and brings learning back to the practice.

The practice had lead clinicians for all the Quality and Outcomes framework (QOF) areas and had templates and clinical protocols available for the team.

The whole clinical team had been trained in joint care planning with patients to improve self-management. Care plans were documented and reviewed regularly.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of emergency department attendances.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

The practice's performance for childhood immunisations for 2013/14 was relatively high compared to other practices in the local area for most immunisations recommended at 12 months, 24 months and at five years of age. The practice had systems in place for invitation and recall of patients when they were due recommended vaccinations.

The local health visiting team were based at the practice premises. The practice staff told us they ran weekly baby clinics which their patients could attend, and that the health visitors attended their clinical meetings.

There was a designated Child Protection clinical lead that maintained a child protection register and ran regular multidisciplinary reviews of all families on the register.

Following feedback from their patients, the practice ran a combined postnatal review, baby 8-week check and first immunisation clinic.

The practice is near Southbank University and actively engaged with students at Fresher's week with registration opportunities and sexual health screening information. They also worked closely with the health advisors based at the university.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this population group.

The practice maintained good liaison with the London Southbank University which was located adjacent to the practice. They manned a stall at their fresher's fairs, where new students were able to register with the practice. They also offered mental health support and sexual health services to the student population.

The practice recognised the difficulty in accessing primary care for working people and had worked to improve this by offering increasing numbers of telephone consultations in place of face-to-face consultations. They provided extended hours sessions on Wednesday and Thursday evenings. They offered online appointment booking, prescription requests and electronic prescribing. They offered NHS health checks for people over the age of 45.

The practice had been involved in the development of a federation of practices in north Southwark. The federation were successful in a Prime Minister's Challenge Fund bid in 2014, and on 01 April 2015 the federation opened an extended access clinic, offering appointments from 8am to 8pm. The practice manager was a director of the federation and had been instrumental in its development. The extended access clinic provided additional capacity for working age patients who have been triaged by their own GPs.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. As of 21 April 2015, there were 34 patients on the practice learning disabilities register. Annual reviews for patients with learning disabilities were provided in the practice or in patients' own homes. A practice nurse and GP visit the residents of a local supported living facility and work closely with staff members.

Longer routine appointments were provided for people with a learning disability.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice held joint clinics with the community mental health teams in the local hostels. They told us that during their last clinic they had seen nine patients in the session.

The practice had significant numbers of hostel dwellers, homeless people and those with substance and alcohol misuse problems registered. Several local hostels registered all their patients with the practice. They were very flexible and worked hard to enable patients to register with them and access all their clinical services.

There was a weekly drug misuse clinic at the practice and the practice team worked closely with local substance misuse teams. An alcohol worker provided appointments and saw patients in the practice.

The practice team told us they maintained a good working relationship with the clinical staff of the local homeless team, and they provided their address for hospital correspondence for homeless patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice patient population included a significant number of people with mental health problems, hostel dwellers and homeless people.

At the time of our inspection there were 187 patients on the practice mental health register, which was proportionately higher than the national average. Of these, 97% had an agreed care plan in place.

People experiencing poor mental health received a range of physical health checks and medication reviews. For example, as of the time of our inspection, 91% had received a blood pressure check in the preceding 12 months, and 93% had their alcohol consumption recorded in the preceding 12 months. Of those eligible, 89% had had cervical screening in the preceding five years. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

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

The practice provided an outreach service to a local residential home for people with learning disabilities. The service was GP led and was supported by other members of the clinical team as required.

The practice worked closely with their local community mental health team (CMHT) and met six monthly with the psychiatrist and their team to discuss patients. A counsellor and psychologist were based in the practice and provided clinical expertise and advice to the team, as well as a service to our patients.

The practice developed joint clinics with the community psychiatrists in local hostels to provide services to these patients that were hard to reach.

One of the practice nurses led in seeing people for physical health reviews and was using the opportunity to screen for long term conditions (LTCs). They did this by carrying out checks such as blood glucose levels, spirometry and dementia screening.

The practice told us they had significantly increased their prevalence of people with dementia, following opportunistic organised screening at annual health checks for LTC and also mental health.

The practice is near South Bank University and worked closely with the University mental health services to provide clinical advice, and supported both the advisors and the students.

Summary of findings

What people who use the service say

We received 28 CQC comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. Twenty three of the comments cards were entirely positive, with patients saying they received a consistently good service, felt well cared for, and that the staff team were helpful and attentive to their needs. Five of the comments cards also included less positive comments which related to the attitude of the reception staff. Some respondents felt their attitude was unfriendly and that they provided only the most basic service. Some patients also mentioned experiencing long delays of up to three weeks in getting appointments.

We spoke with 14 patients during our inspection. They all commented positively about their care and treatment experiences, and the quality of the clinical care they received. Three of the patients we interviewed also made slightly less favourable comments, relating to the delays they sometimes experienced in being attended to by the reception staff when they visited the practice.

We spoke with one member of the practice Patient Participation Group (PPG). They told us they enjoyed a good working relationship with the practice staff team, and that they felt supported in promoting the PPG's agenda and priorities. They told us they found the practice team open and transparent, and listened and responded to their feedback.

Data from the 2014 national GP patient survey showed that the practice performed particularly well against the local average in terms of the quality of their GP consultations. For example, 85% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, whilst the local area and national averages were 78% and 83% respectively; 89% of respondents said the last GP they saw or spoke to was good at listening to them, the local and national averages were 83% and 87% respectively; and 87% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments, the local average and national averages were 79% and 82% respectively.

Data from the national GP patient survey showed that the practice performance was similar to the local area and national averages in terms of overall patient experience and satisfaction: 82% of respondents described their overall experience of this surgery as good; the local and national results for this question were 80% and 85% respectively. In addition, 77% would definitely or probably recommend the surgery to someone new to the area; the local and national results were 73% and 78% respectively.

Areas for improvement

Action the service SHOULD take to improve

- Ensure infection prevention and control policies and procedures are kept under review and up to date
- Ensure portable appliance testing (PAT) and fire safety checks are completed at required intervals.

Outstanding practice

We found the following areas of outstanding practice:

The practice was particularly effective in supporting patients with long term conditions. Data from the Southwark population health services showed that the practice had achieved double its target for the 2014 /15 year in collaborative care planning for patients with certain long term conditions. The practice was a high QOF

Summary of findings

achiever, their performance for clinical domain indicator groups was better than the local and national averages for all diseases reported. The practice performance was 100% for all but two groups.

The practice is near Southbank University and actively engaged with students at Fresher's week with registration opportunities and sexual health screening information. They also worked closely with the health advisors based at the university. They also offered mental health support and sexual health services to registered students.

Princess Street Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor and an expert by experience. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Princess Street Group Practice

Princess Street Group Practice is located at Elephant and Castle in South East London. The practice is a member of Southwark Clinical Commissioning Group, and is part of their southern locality network.

Being based in inner London, the practice is in an area that has some inner city area characteristics including deprivation, ethnic diversity and a younger population. The practice is situated in an adjacent building to London South Bank University, and therefore has a significant number of patients who were students. The practice has a mobile population, and typically has a 20% list turnover every year.

At the time of our inspection there were 11826 registered patients in the practice.

The staff team are five partners, who were four GPs and the practice manager, four salaried GPs, three GP registrars, two nurse practitioners, three practice nurses and a healthcare assistant. There was one male GP in the practice. They were supported by a practice management team that comprised of a practice manager, a patient services manager, and a team of administrative and reception staff. Attached staff to the practice included a health visiting team that is based in the practice, counsellor, psychologist, midwife, dietician and alcohol and drug workers.

Princes Street Group Practice is a training practice, and has trained over 80 new GPs in the time they have been at Princess Street. Three of their GPs were GP trainers, two of the GPs teach medical students, and one of the GPs is a medical students examiner. The practice's GP trainers, the practice systems, staffing and organisation is regularly assessed through the London Deanery who approved them as a training practice. The practice also trains other medical staff including medical undergraduates and pharmacists.

The practice had a personal medical services (PMS) contract for the provision of its general practice services. Services provided in the practice include general medical services which was through a telephone triage system for same day appointments, mother and baby clinic, contraceptive services, minor surgery and wart clinic, drug and alcohol clinic, counselling and psychology, and ambulatory blood pressure monitoring.

Princes Street Group Practice is registered with the Care Quality Commission (CQC) to carry on the regulated activities of Diagnostic and screening procedures; Treatment of disease, disorder or injury; Maternity and midwifery services; Family planning services; and Surgical procedures to everyone in the population. These regulated activities are provided from the practice site at 2 Princess Street. Elephant and Castle. SE1 6JP.

The practice is open between 8:00am and 6:30pm on Mondays, Tuesdays and Fridays; and between 8:00am and

7:30pm on Wednesdays and Thursdays. Appointments times are from 9:00am to 11:30am and from 2:00pm to 5:00pm on Mondays, Tuesdays and Fridays and from 9:00am to 7:30pm on Wednesdays and Thursdays.

The practice had opted out of providing out-of-hours services to their patients, and had contracted an external provider to provide out of hours services.

Why we carried out this inspection

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

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

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 April 2015.

During our visit we spoke with a range of staff (GPs, nursing staff, practice manager, patient services manager, administrative and reception staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, following an incident where there was a delayed diagnosis as test results were not promptly returned from the labs, and when eventually available were not reviewed and acted on, the practice liaised and reviewed with the labs about the provision of test results. In addition, arrangements were put in place to cover the review and action of their patients' test results when a GP was away.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 15 significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every six months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice shared computer drive and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared through staff meetings. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager and clinicians to practice staff. Staff we spoke with was able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical team meetings to ensure staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

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

The practice submitted reports for case conferences to discuss vulnerable children. The local health visiting team was based on the practice premises, so the practice was able to closely liaise with them in the provision of additional care and support to vulnerable children.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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). Six members of staff, including some reception staff and the practice manager, had been trained to act as chaperones and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Reception staff would act as a chaperone if nursing staff were not available.

Clinical staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS 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). DBS checks were not completed for non-clinical staff who acted as chaperones. For the non-clinical staff, a risk assessment was in place which considered if the chaperone is left alone with the patient, and concluded that would not be the case.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked a sample of anonymised patient records which confirmed that the procedure was being followed.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw a set of PGDs for the diphtheria, tetanus, and whooping cough (pertussis) (Dtap) vaccine recommended to be administered to children. The PGDs had been kept under review and up to date at the time of our inspection.

The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by a prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example,

personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. However the policy was in need of update as it referred to the cleaning of fabric furnishings which was not in use in the practice. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had an appointed lead for infection prevention and control who told us they had been informed about the responsibilities associated with the role by a previous external IPC auditor. The IPC lead had attended formal training for the role in 2008. The practice manager told us they had provisionally booked the IPC lead on some LMC Londonwide training on 13th October 2015 and were awaiting confirmation.

All staff received induction training about infection control specific to their role.

The practice provided us with evidence of the IPC audits that had been carried out in the practice over the last four years. With the exception of the audit carried out in 2012 by the public health infection control nurse for NHS Southwark, the other audits had been carried out by the IPC lead supported by the practice manager. Actions identified from the audits were being worked through by the practice team.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had contracted an external company to undertake a risk assessment for legionella (a bacterium which can contaminate water systems in buildings) in November 2013. We saw evidence that the practice had completed recommended actions identified following the assessment such as carrying out a boiler service.

At the time of their registration with the CQC, the provider declared themselves non-compliant with a minor impact against the regulation relating to infection control. This was because their latest infection control audit and premises survey had identified that a number of consultation rooms were in need of upgrade to meet the recommendations of national guidance on infection control. They also had some seating that was not wipe able and needed to be replaced. The provider completed works on the premises upgrade in February 2013 and replacing seating in September 2013.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. However the portable appliance was due to be retested in December 2014.

A schedule of testing was in place. We saw evidence of calibration of relevant equipment including weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The most recent equipment calibration had been carried out in February and April 2015.

At the time of their registration with the CQC, the provider declared themselves non-compliant with a minor impact against the regulation relating to premises. This was because there were a number of equipment tests and premises tests that were in need of renewal. These included portable appliance testing (PAT), legionella disease risk assessment, disability audit, and ventilation systems in some consultation rooms that were in need of upgrade. They told us they expected to complete the relevant equipment testing by December 2012, and the premises upgrade by February 2013. At our inspection, we saw that the tests and upgrade was being maintained.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service, or DBS. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where

Good

Are services safe?

they may have contact with children or adults who may be vulnerable). The practice had a policy to carry out DBS checks for all clinical staff and the practice manager, and to repeat these checks every five 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 absences, such as during periods of annual leave.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. They contracted an external company to complete an annual health and safety risk assessment, which was last completed in June 2014. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

An external company was contracted to carry out an annual fire risk assessment and fire alarm system testing, with the most recent assessment having been completed within the last 12 months. The fire extinguishers had last been serviced in November 2014.

Identified staff were required to carry out weekly fire safety checks. The records showed these had not been completed to the set frequency in recent months.

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, which included the use of an automated external defibrillator (AED). Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they took clinical lead roles across all clinical areas, and the practice nursing team supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened, and that guidance relating to the management of various long term conditions were discussed.

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

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

Management, monitoring and improving outcomes for people

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

The whole practice team participated in audits, reviews and incidents management. The practice had a culture of learning and improvement. For example they had undertaken a repeat prescribing audit in response to patient complaints and feedback from their PPG. This led to a work plan being developed to improve the practice's ability to achieve the 48 hour turnaround for repeat prescription requests.

Following a significant event analysis which led to a change in practice, a warfarin monitoring audit was initiated. The change in practice was also discussed with the local CCG district nurses.

The practice had a system in place for completing clinical audit cycles. The practice showed us two completed audit cycles: the first was of drugs interfering with tamoxifen, and the second was of the review of the care of patients with prostate cancer. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved.

The tamoxifen audit was initiated following a GP attendance at a cancer care update training session, and also in response to a Medicines & Healthcare products Regulatory Agency (MHRA) alert about the medicine. The aim was to ensure patients meeting the audit criteria were

not taking any medicines that interfered with tamoxifen. The first cycle of the audit was carried out in August 2014 and identified a number of patients taking drug combinations that were not recommended. The audit results and the recommended guidance were shared with the clinical team on 02 September 2014, with notes to the patients' regular GPs to review their prescribing. A second cycle of the audit was carried out in January 2015 and found that all patients were now on suitable drug therapies. No new patients were taking Tamoxifen since the audit started. A new alert was added to the electronic records and prescribing system to any prompt anyone prescribing tamoxifen to avoid certain medicines in line with guidelines.

The audit of care of patients with prostate cancer was triggered by a significant event where a person with the illness had not been referred to the urology specialist following a rise detected in their PSA result at their annual check-up. The PSA (prostate-specific antigen) is a blood test that can detect the early signs of an enlarged prostate. The aim of the audit was to ensure that all prostate cancer patients were being appropriately followed up. The first cycle of the audit was carried out in December 2012, and found that of the 30 patients who had the illness, there were two patients who did not have a clear plan of follow up. Following the first cycle, additional information was added to all patient notes, indicating who was responsible for monitoring their PSA and what level of PSA was acceptable and at what point they should be referred. The second cycle of the audit was carried out in August 2014. Of the 32 patients included in the audit, only one of these patients had not had their PSA checked for more than a year the rest had. The patient was written to by the practice and they were advised they needed to get a PSA done. The audit concluded that there was a need to communicate to patients clearly the need to have annual PSA tests done.

The practice also provided us with a summary of further audits undertaken in last 12 months. Eight clinical audits had been undertaken in the last 12 months. One of these, inadequate cervical cytology, was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. Other examples included audits of the telephone triage system, review of insurance/solicitors reports, and smoking cessation.

The GPs told us clinical audits were often linked to medicines management information, significant events, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 99% of the total QOF target in the year ending 31 March 2014, which was 7.3% and 5.5% above the local area and national averages respectively. Specifically, the practice performance for clinical domain indicator groups was better than the local and national averages for all diseases reported. The practice performance was 100% for all but two groups.

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

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

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

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in

Good

Are services effective?

(for example, treatment is effective)

various vulnerable groups, such as people living in hostels, people with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions, such as hypertension, diabetes, and heart failure.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice was performing significantly better than other practices against a range of indicators, including minor A&E attendances, referrals to the admissions avoidance support services, alcohol screening, and referral rates to Improving Access to Psychological Therapies (IAPT) services.

Data from the Southwark population health services showed that the practice had exceeded its target for the 2014 /15 year in collaborative care planning for patients with certain long term conditions, diabetes, hypertension and chronic obstructive pulmonary disease (COPD). The year's target was 337 patients, but the practice had completed collaborative care planning for 748 patients.

The practice participated in the delivery of the elderly care pathway during the two years prior to our inspection. The pathway involved practice based holistic health assessments, home based health assessments and case management. During the 2013 / 14 year, they carried out 72 assessments in the practice and 19 in patients' homes. During the 2014 /15 year, the figures were 89 assessments and 55 assessments respectively. During the 2014 / 15 year the practice also case managed 33 patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors and they had a range of additional diplomas and specialism including obstetrics and gynaecology, and geriatric medicine.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, and offered a range of mandatory training courses for staff as well as specialised courses for professional development. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

The practice nursing team included two advanced nurse practitioners who were independent nurse prescribers, and a practice nurse who was also an independent nurse prescriber.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and in cervical cytology. Those with extended roles saw and reviewed patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues that arose from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Good

Are services effective?

(for example, treatment is effective)

Emergency hospital admission rates for the practice were similar to expected and comparable to the national average. The practice had an emergency cancer admissions rate per 100 patients on the register for year ending 31 March 2014 that was similar to expected.

For the same period, the practice had an emergency admissions rate for 19 Ambulatory Care Sensitive Conditions of 16.26 per 1000 patients; the national average rate was 13.6 per 1000 population.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for taking action on hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed. The practice had emergency admissions rates that was similar to the expected and national figures.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, there were weekly clinical meetings that were sometimes attended by external professionals such as members of the health visiting team or mental health teams. The practice also held three monthly palliative care meetings. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice is part of a local GP federation delivering population services and extended hours access. The practice had opted out of providing its own out of hours services, which it had contracted to another organisation to provide.

The practice worked collaboratively with local authority, community services and secondary care in the delivery of care. They had a close working relationship with the local mental health trust and provided joint visits to patients in the community and within the practice.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 (MCA 2005), the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, we saw evidence that the practice had followed the principles of the MCA 2005 and had ensured appropriate processes were followed so that decisions were made in the best interest of the patient. We saw that records were maintained of how patients had been supported to make their own decisions and how these should be documented in the medical notes.

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

Good

Are services effective?

(for example, treatment is effective)

section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

It was practice policy to offer a health check 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. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 96% of their patients with chronic disease and actively offered healthcare assistant-led smoking cessation clinics to 92% of these patients.

The practice's performance for the cervical screening programme was 83% for the year ending 31 March 2015, which was above the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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

- Flu vaccination rates for the over 65s were 69%, and at risk groups 58%. The rates for the over 65s was slightly below the national average of 73%, and the vaccination rates among the at-risk groups were higher than the national average of 52%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 84% to 95%, and five year olds from 72.1% to 95.3%. These were comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey (published on 08 January 2015) and the results of the friends and family test.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the GP patient survey showed the practice was rated better than the local area average for patients who rated the practice as good or very good; the practice value was 81.8% compared to the CCG average of 79.9% and the national average of 85.2%. The practice was also above average for its satisfaction scores on consultations with doctors:

- 88.5% said the GP was good at listening to them compared to the CCG average of 83.2% and national average of 87.2%.
- 87% said the GP gave them enough time compared to the CCG average of 79.7% and national average of 85.3%.
- 92.6% said they had confidence and trust in the last GP they saw compared to the CCG average of 89.2% and national average of 92.2%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards and the majority were positive about the service experienced. Twenty three of the comments cards were entirely positive, with patients saying they received a consistently good service, felt well cared for, and that the staff team were helpful and attentive to their needs. Five of the comments cards also included less positive comments which related to the attitude of the reception staff. Some respondents felt their attitude was unfriendly and that they provided only the most basic service. Some patients also commented that they experienced long delays of up to three weeks in getting appointments.

We spoke with 14 patients during our inspection. They all commented positively about their care and treatment experiences, and the quality of the clinical care they received. Three of the patients we interviewed also made slightly less favourable comments, relating to the delays they sometimes experienced in being attended to by the reception staff when they visited the practice.

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

We found that due to the layout of the premises, the practice reception area did not allow for confidential conversations to be held. The practice switchboard was located at the reception desk, and patients making enquiries or registering their arrival for their appointments also came to speak with the reception staff in the same area. However staff told us that patients who needed to discuss any matter in private with them were able to talk to staff in a separate area or room.

The GP patient survey results showed that 76% said they found the receptionists at the practice helpful compared to the CCG average of 84.9% and national average of 86.9%. In response to patient feedback and complaints about attitude of reception staff, the practice management had arranged for the reception team to attend a personal development course to help them explore attitudes and behaviours, equip them to deal more competently with a range of different situations and also understand the impact of their behaviour and attitudes on their colleagues and patients. Reception staff we spoke with who had attended the course told us it had been beneficial to their development and enjoyable.

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

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

Care planning and involvement in decisions about care and treatment

Good

Are services caring?

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

- 87.2% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79.2% and national average of 82%.
- 84% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 70.8% and national average of 74.6%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice GPs and rated it well in this area; however they rated the nurses slightly less favourably:

- 84.9% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77.6% and national average of 82.7%.
- 67.9% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 71.1% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were mostly positive, and patient said they felt well cared for.

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a Patient Participation Group (PPG) that had been in operation for about six years. The practice had involved the PPG in the development of their in-house surveys, reviewing the feedback they received from various sources and preparing action plans and service priorities.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example their appointments availability had been designed around their patients' needs, and services such as child and antenatal clinics, sexual health services and travel health, were provided around the needs of their populations. The practice also recognised and adapted to the needs of particular groups, such as older people, students, and people of no fixed abode.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The annual PPG report showed the group had identified three particular areas that they wanted the practice to focus on improving in the current year: review of repeat prescription system and the electronic prescribing system, length of time to get discharge letters to the practice from the local hospital, and improvement of services provided by reception team.

The practice recognised the difficulties of meeting patient access demands (appointments availability) and had implemented a number of innovations to improve access for its patients. These included a telephone triage system introduced in August 2014 to help manage on the day access. The practice was also making increased use of scheduled telephone consultations and nurse follow ups, results being handled by nurses in daily telephone consultations, an electronic prescribing system with functionality for online prescription requests. The GP federation that the practice is a part of introduced an extended access clinic, 8am to 8pm, and 7 days a week. The practice could refer patients to the extended access clinic which is based at a local health centre.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises had been refurbished to some extent to meet the needs of people with physical disabilities. The practice was accessible to patients with mobility difficulties with access to the first floor consultation rooms available via a ramp situated external to the premises. The consulting rooms were accessible for patients who were wheelchair users and there were access enabled toilets and baby changing facilities.

There were two waiting areas, on the ground floor and upper floor. The ground floor waiting area lacked space and there was limited room for wheelchairs and prams.

Staff we spoke with were able to describe the process they followed to register patients who were of "no fixed abode". They were registered to the practice's address, so that relevant correspondence about their care and treatment was received directly in the practice. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could have their wishes fulfilled around the preferred gender GP they saw.

Access to the service

The practice is open between 8:00am and 6:30pm on Mondays, Tuesdays and Fridays; and between 8:00am and 7:30pm on Wednesdays and Thursdays. Appointments times are from 9:00am to 11:30am and from 2:00pm to 5:00pm on Mondays, Tuesdays and Fridays and from 9:00am to 7:30pm on Wednesdays and Thursdays.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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

In August 2014, the practice began operating a telephone triage system for patients who wished to be seen on the day. Patients who felt they had an urgent problem needed to telephone the practice between 8.30am and 10.30am, and the reception staff would take their contact details, and brief description of the problem if they felt comfortable providing this information. A GP or a nurse practitioner would then call the patient back to discuss the problem and if necessary offer them a same day appointment. Ring-fenced appointments were made available for the telephone triaged patients, and these were released daily.

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

- 73% were satisfied with the practice's opening hours compared to the CCG average of 74.6% and national average of 75.7%.
- 71.2% described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73.8%.
- 71.7% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 54.3% and national average of 65.2%.
- 68.3% said they could get through easily to the surgery by phone compared to the CCG average of 71.6% and national average of 71.8%.

Most patients we provided feedback to us were satisfied with the appointments system and said it was easy to use. A few patients we spoke with and some that completed CQC comments cards were not entirely satisfied with the appointments system, and highlighted they experienced long delays getting appointments, and long waits to be seen for their appointments.

Listening and learning from concerns and complaints

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

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

We looked at the details of the 21 complaints received in the 12 months leading up to our inspection. We found that these were satisfactorily handled, dealt with in a timely way, and that there was openness and transparency in dealing with the complaints.

The practice had reviewed the complaints received in the past year to detect themes or trends. Where themes or individual issues were identified these were handled appropriately.

Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision, which had three strands: to deliver high quality care, provide training for staff and for the GPs to bring added value to the practice. The practice vision and values included treating patients with respect and concern, developing new services for the benefit of their patients, and to continue their tradition of teaching and training clinical staff.

The staff we spoke with shared the practice vision and values, and knew what their responsibilities were in relation to them. The practice had good staff retention.

Governance arrangements

The practice has twice achieved the Royal College of General Practitioners (RCGP) Quality Practice Award (QPA), for 2005 to 2010, and for 2011 to 2016. The award is given to general practitioner practices in the United Kingdom to show recognition for high quality patient care by all members of staff in the team. The QPA is the highest attainable award from the RCGP, and recognises practice teams who have demonstrated both clinical and organisational excellence in the delivery of primary care.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a range of these on the practice's computer system and most staff had completed a cover sheet to confirm that they had read the policy and when. Most of the policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. There were clinical leads appointed for specific areas of practice, all reporting to the practice's quality lead. There were clearly defined areas of responsibility and expertise, such as child protection lead, and palliative care lead. There was a lead nurse for infection control and a senior partner was the lead for safeguarding.

The members of staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The senior members of the practice clinical teams had several externals roles within the local health economy, including chair of the LMC, Director of the local GP federation, Diabetes chair for the local CCG and lead GP for the potential merger of four local practices.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using 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 it was performing above the local area and national averages. For the 2013 / 14 year, the practice achieved an overall score of 99%, which was 7.3 percentage points above local area average, and 5.5 percentage points above the England average. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Recent audits undertaken in the practice included one of drugs interfering with tamoxifen, and the second was of the review of the care of patients with prostate cancer. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example health and safety checks and fire risk assessments. At the time of our inspection, we noted that the portable appliance testing was due for retest in December 2014.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the induction policy and the recruitment policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that there were weekly clinical meetings every Tuesday.

The nurses and the reception teams also had regular meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.

The senior management team held annual away weekends to review the year and plan for the year ahead.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from different age groups and ethnicities. The PPG met every quarter. The practice manager showed us the analysis of the last patient survey and their latest friends and family test results, which were considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

We spoke with the chair of the practice's PPG. They were positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). A GP and the practice manager attended the PPG meetings. The PPG chair had been invited to attend a reception staff team meeting to discuss complaints that had been made about the team. The practice had provided feedback to the PPG about improvements they were making in response to these complaints, which included providing staff with additional training and supervision.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through away days, staff meetings, appraisals and discussions). Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice, and had a long standing history of training and development of clinical professionals. The GP partners provided mentoring to all the salaried GPs and advanced nurse practitioners.

GPs and the practice manager held external roles, such as medical students examiner and directorship within the local GP federation.

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