The Rosendale Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Rosendale Surgery, located in West Dulwich in the London borough of Lambeth provides a general practice service to around 5,700 patients.

We carried out an announced comprehensive inspection on 12 November 2014. The inspection took place over one day and was undertaken by a lead inspector, along with a GP advisor, a specialist advisor with a background in practice management and an Expert by Experience. We spoke with patients, members of the patient participation group (PPG), and staff including the management team.

Overall the practice is rated as Good.

Our key findings were as follows:

• The service is safe. There were systems in place for reporting, recording and monitoring significant events to help provide improved care. Staff were clear of their roles in regards to monitoring and reporting of incidents, safeguarding vulnerable people and children, and following infection prevention and control guidelines.

• The service is effective. Staff shared best practice through internal arrangements and meetings and also by sharing knowledge and expertise with external consultants and other GP practices. There was strong multidisciplinary input in the service delivery to improve patient outcomes.

• The practice is caring. Feedback from patients about their care and treatment via the national and practice-run surveys was very positive. Patients were treated with kindness and respect and felt involved in their care decisions. Almost all the comment cards completed by patients who used the service in the two weeks prior to our inspection visit had very positive comments about the care and service provided by the surgery.

• The practice is responsive to people's needs. The practice had an active Patient Participation Group (PPG) and worked with them to improve the service. The practice was responsive to the needs of the vulnerable patients and there was a strong focus on caring and on

Summary of findings

the provision of patient-centred care. Information on health promotion and prevention, services provided by the practice and the support available in the community was available for patients.

• The practice is well-led. The practice had a clear vision and strategic direction, was well-led, staff were suitably supported and patient care and safety was a high priority.

We saw areas of outstanding practice in the joint working with the Patient Participation Group. Some instances included:

- Recognising the trend on complaints regarding appointment access, The practice discussed the various models of appointments systems they had researched with the PPG. The PPG then agreed with the practice the model they would pilot from April 2014.
- Joint working to gain approval for the business plans to relocate to a new purpose built surgery in 2016.

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

The provider should:

Ensure the risk log is updated regularly.

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 good for safe.

We found that suitable arrangements were in place for medicines management, infection control, staff recruitment, and dealing with medical emergencies. Risks to patients were assessed and well managed and there were systems and processes in place to raise concerns. There was a culture of reporting and learning from incidents within the organisation. Lessons were learned and communicated widely to support improvement. Staff we spoke with were trained in and aware of their responsibilities for safeguarding vulnerable adults and child protection. The equipment and the environment were maintained appropriately, and staff followed suitable infection control practices. Vaccines and medicines were stored suitably and securely and checked regularly to ensure they were within their expiry dates.

Are services effective?

Good

The practice is rated good for effective.

There were suitable systems in place for assessment of patient needs, and care and treatment was delivered in line with current legislation and best practice. This included assessment of capacity to make decisions and the promotion of good health. Audits of various aspects of the service were undertaken at regular intervals and changes were implemented to help improve the service. The practice worked with other health and social care services, and information was shared with relevant stakeholders such as the Clinical Commissioning Group (CCG) and NHS England to improve outcomes for patients. Staff received training appropriate to their roles and were supported in their work and professional development.

Are services caring?

Good

The practice is rated good for caring.

The patients and carers we spoke with were complimentary about the care and service that staff provided and told us they were treated with dignity and respect. They felt well informed and involved in decisions about their care. Accessible information was provided to help patients understand the care available to them. In our observations on the day we found that staff treated patients with empathy and respect.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated good for responsive.

Patients' needs were suitably assessed and met. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and the CCG to secure service improvements where these were identified. There was good access to the service with urgent appointments and telephone contact available the same day and routine appointments available within 24-48 hours. Feedback from patients was obtained proactively and the service acted accordingly. The practice learnt from people's experiences, concerns and complaints to improve the quality of care. Arrangements had been made to help vulnerable people access care. The treatment and consulting room, the reception area and the patient toilets on the ground floor were wheelchair accessible.

Are services well-led?

Good

The practice is rated as good for well-led.

The practice was well-led and the culture within the practice was open, transparent and one of learning and improvement. 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 staff had access to these policies. Risks to the effective delivery of the service were assessed and there were suitable business continuity plans in place. The practice had an active Patient Participation Group (PPG). The staff were well supported, worked closely together and felt able to raise concerns. Meetings were undertaken regularly, and staff received suitable training.

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.

The practice was responsive to the needs of older people including those with dementia and offered a proactive, personalised care to meet their needs. Older people were cared for with dignity and respect and there was evidence of working with other health and social care providers to provide safe care. Support was available in terms of home visits and rapid access appointments for terminally ill and housebound patients.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

The clinical staff had the knowledge and skills to respond to the needs of patients with long term conditions such as cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD). Staff worked with other health professionals, such as for example, diabetes specialists to ensure a multi-disciplinary approach, and the care and medicines of patients in this group were reviewed regularly.

Families, children and young people

Good

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

There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. Staff had received training on child protection which included Level 3 for GPs and nurses. There was evidence of joint working with other professionals to provide good antenatal and postnatal care. Baby immunisation clinics and mother and baby clinics with a nurse and GP were available and childhood immunisations were administered in line with national guidelines. Appointments were available outside of school hours and there was evidence of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students).

Summary of findings

The needs of the working age population, those recently retired and students had been identified and there was a variety of appointment options available to patients such as telephone consultations, on-line booking and extended hours. The practice offered health checks, travel vaccinations and health promotion advice including on smoking cessation.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable.

People attending the practice were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing and staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and guided the patients to various support groups and third sector organisations. The practice was signed up to the learning disability enhanced service to provide an annual health check for people with a learning disability to improve their health outcomes. People with learning disabilities were offered longer appointments and the practice was on track to provide these checks within the financial year.

People experiencing poor mental health (including people with dementia)

Good

The practice provided a caring and responsive service to people experiencing poor mental health.

The practice was signed up to the dementia enhanced service to provide care and support for people with dementia. The services were planned and co-ordinated to ensure that patient's needs were suitably assessed and met. Reviews of care records of patients with dementia and mental health issues showed they were receiving adequate multi-disciplinary support and annual reviews of their health. Staff told us that they could also refer patients to access support from the community mental health teams.

Summary of findings

What people who use the service say

The four patients and the PPG members we spoke with on the day of our visit told us that they were treated with kindness and respect both by doctors and nurses and by the practice reception staff. We received 12 comment cards from patients who attended the practice during the two weeks before our inspection and almost all were complimentary of the care they received from the surgery staff.

The 2013/14 GP survey results (latest results published in July 2014) showed that 95% of respondents had confidence and trust in the last GP they saw or spoke to (compared with a Lambeth CCG average of 91%). Sevety four per cent of the respondents said that the last nurse they saw or spoke to was good at giving them enough time (Lambeth CCG average of 72%).

The 2014 PPG patient survey report found that 94% of respondents felt their GP involved them in decisions about their care, 98% felt their GP explained the proposed treatment and 94% felt their GP addressed any concerns they had.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the practice's risk log is updated regularly.

Outstanding practice

The practice demonstrated outstanding joint working with its Patient Participation Group. Some instances included-

- Recognising the trend on complaints regarding appointment access, the practice researched various models of appointment systems and discussed them with the PPG. The practice then agreed with the PPG the model they would pilot from April 2014.
- Joint working to gain approval for the business plans to relocate to a new purpose built surgery in 2016.

The Rosendale Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector. The team included a GP, a practice manager and an Expert by Experience.

Background to The Rosendale Surgery

The surgery, which operates from a single location, is located in West Dulwich in the London borough of Lambeth and has a list size of just around 5,700 patients.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; family planning; and maternity and midwifery services.

The practice has a Personal Medical Services (PMS) contract and provides a range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic and contraception services. (Personal Medical Services agreements are locally agreed contracts between NHS England and a GP practice and offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contracts).

The practice is currently open five days a week from 8:00am to 6:30pm. In addition, the practice offers extended opening hours from 6:30pm to 8:00pm every Monday and one Saturday every month from 9.00am to 12.00pm. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to an out-of-hours service when the surgery is closed.

The surgery is currently situated in a converted and extended retail unit in a Victorian building on the high street. The surgery is not purpose built and its shortcomings include an outdated internal layout and limited waiting room area. We were shown the business plans that had been approved for re-location and the practice, we were told, would be moving to a new location in 2016.

The practice has a higher than average percentage of patients under 18 years of age and in the 30-49 year age groups.

The surgery clinical staff included three partners (one male and two female), two regular locum GPs, two nurses and one healthcare assistant. The practice also has a practice manager and an administration and reception team with six receptionist staff.

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.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as Healthwatch, CCG and NHS England to share what they knew. We carried out an announced visit on 12 November 2014. During our visit we spoke with a range of practice staff (GP partners, practice manager and the reception staff). We talked with four patients and/or family members, members of the patient participation group (PPG) and reviewed personal care or treatment records of patients. We reviewed 12 comment cards where patients shared their views and experiences of the service.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice manager told us of the arrangements they had for receiving and sharing safety alerts from other organisations such as the Medicines and Healthcare Products Regulatory Authority (MHRA) and NHS England. The practice had a significant event protocol and used reported incidents, national patient safety alerts as well as comments and complaints received from patients to help improve the service. All the staff we spoke with were aware of identifying concerns and issues and reporting them appropriately. We reviewed a sample of seven safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently. In addition to discussions in meetings, we were told that the significant events were reviewed quarterly to ensure any themes were identified and discussed.

Learning and improvement from safety incidents

The practice had an effective system in place for reporting, recording and monitoring incidents and significant events. There was evidence of learning and actions taken to prevent similar incidents happening in the future. Review of the incident records showed evidence of discussion and learning. We reviewed an incident involving an acutely ill child. This incident had been identified as one where staff had not followed the appropriate protocol in raising alarm. We saw evidence of discussions to help improve the internal communications.

Reliable safety systems and processes including safeguarding

The practice had policies in place relating to the safeguarding of vulnerable adults, child protection and whistleblowing. One of the partners was the designated lead for safeguarding. Staff we spoke with were aware of their duty to report any potential abuse or neglect issues. Clinical staff including two of the GPs and one nurse had completed Level 3 child protection training and the reception staff had received Level 1 training. Dates had been booked for the Level 3 training for the other GP. Staff had also received training in safeguarding vulnerable adults and all staff were required to have a criminal records (now the Disqualification and Barring Scheme) check. The contact details of the local area's child protection and adults safeguarding departments were accessible to staff if they needed to contact someone to share their concerns about children or adults at risk.

The practice maintained a register of children who were considered at risk of neglect. Alerts were also set up on the computer system to alert staff to patients with multiple co-morbidities and on polypharmacy as well as those who were house-bound. This helped improve staff awareness and vigilance of children and adults who were at potential risk of neglect. There was evidence of discussion amongst practice staff around safeguarding children and vulnerable adults. The practice had a chaperone policy, and information on availability of chaperones was displayed in the practice. The practice currently used only the clinical staff to act as chaperones but was looking to provide chaperone training to non-clinical staff as well.

Medicines Management

The practice had procedures in place to support the safe management of medicines. Medicines and vaccines were safely stored, suitably recorded and disposed of in accordance with recommended guidelines. We checked the emergency medicines kit and found that all medicines were in date. The vaccines were stored in suitable fridges at the practice and the practice maintained a log of temperature checks on the fridge. Records showed all recorded temperatures were within the correct range and all vaccines we checked were within their use by date. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice.

Cleanliness & Infection Control

Effective systems were in place to reduce the risk and spread of infection. Staff had received training in infection prevention and control and were aware of infection control guidelines. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. There was also a policy

for needle stick injury. Hand washing sinks, hand cleaning gel and paper towels were available in the consultation and treatment rooms. Equipment such as blood pressure monitors, examination couches and weighing scales were clean and an infection control audit had been undertaken in the last six months. Clinical waste was collected by an external company and consignment notes were available to demonstrate this.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. These included annual checks of equipment such as portable appliance testing (PAT) and calibrations, where applicable. These tests had been undertaken within the last year.

Staffing & Recruitment

A staff recruitment policy was available and the practice was aware of the various requirements including obtaining proof of identity, proof of address, references and undertaking criminal records (now the Disqualification and Barring Scheme) checks before employing staff. Records we sampled showed that DBS checks had been completed for staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they was enough staff on duty. 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 ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice manager explained the systems that were in place to ensure the safety and welfare of staff and the patients using the service. In the notes of the practice's meetings, we saw that a medical emergency concerning an acutely ill child had been discussed and appropriate learning taken place. Risk assessments of the premises including health and safety, Control of Substances Hazardous to Health (COSHH), Legionnaires' disease, security, and fire had been undertaken. The fire alarms were tested regularly. Risks, like staffing issues resulting from staff absences and retirement, premises safety and fitness for purpose had been discussed in meetings. A risk log was available, though the provider may wish to note that risk document hadn't been updated in over six months.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. All staff had received training in basic life support. The practice had a stock of emergency equipment such as oxygen, masks and nebulisers and emergency medicines including those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The equipment was checked regularly. The practice had undertaken a risk assessment and was planning to acquire an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

A business continuity plan was available and the practice manager told us of the contingency steps they could undertake in the event of any disruption to the premises' computer system, central heating, and telephone lines. They told us of the arrangements they had with other providers to ensure patient care could be undertaken with minimal disruption in the event of such incidents.

The surgery was currently situated in a converted and extended retail unit in a Victorian building in a small parade of shops on the high street. The surgery was not purpose built and amongst other shortcomings had limited waiting room area with seating for patients close to the reception desk. Also, the building was in a poor state of repair. We were shown the business plans that had been approved for re-location and the practice we were told would be moving to a new location in 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs reviewed incoming guidelines such as those from the National Institute for Health and Care Excellence (NICE) and, if considered relevant, they were discussed in practice clinical meetings and by e-mails. There was evidence of a good working relationship between the professionals to ensure information was cascaded suitably and adapted accordingly. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

There was evidence that staff shared best practice via internal arrangements and meetings. The practice had good peer reviewed referral management system whereby complex cases and referrals were discussed internally with colleagues. Review of care records and discussions with staff showed that GPs used evidence based guidelines in determining the treatment options for their patients who were supported to achieve good health outcomes.

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

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were on appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which ensured that the practice contacted all patients discharged from hospital whose care was reviewed by their GP according to need.

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and manage outcomes to help provide improved care. The GPs and the practice manager were actively involved in ensuring important aspects of care delivery such as significant incidents recording, clinical review scheduling, data input, child protection alerts management, referrals, and medicines management were being undertaken suitably. The practice showed us completed clinical audits they had undertaken such as on prescription of Statins and anti-coagulants to monitor their compliance with current guidance. These audits confirmed that they were doing so in line with current best practice.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). [QOF is a voluntary incentive scheme used to encourage high quality care, with indicators to measure how well practices are caring for their patients]. For example we were told by one of the GPs that they had altered their prescribing practice following analysis of prescribing data of 2013, to be more in line with the current guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

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 upon 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.

Good

Are services effective?

(for example, treatment is effective)

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. The practice also 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 had outcomes comparable to other services in the area.

There was evidence from review of care that patients with dementia, learning disabilities and those with mental health disorders received suitable care with annual review of their health and care plan.

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 basic life support, safeguarding and infection control. A good skill mix was noted amongst the doctors. All GPs were up to date with their yearly continuing professional development requirements and all were due in 2015/16 for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). Staff we spoke with told us they were clear about their roles and responsibilities, had access to the practice policies and procedures, and were supported to attend training courses appropriate to the work they performed.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The GP seeing 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. We did not find any instances of any results or discharge summaries which were not followed up appropriately.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patents e.g. those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice regularly attended the network meetings and was engaged in contributing to their network. We found the practice was open to sharing and learning and engaged openly on pathways and multi-disciplinary team meetings.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system also helped in documenting communications with other providers.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities 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. The practice records showed 100% care plans had been reviewed in last year. Staff gave us an example of how a patient's best interests were taken into account in planning a treatment when the patient did not have the mental capacity for making the decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

There was a range of information available to patients in the waiting areas which included leaflets and posters providing information on the various services, flu vaccinations and smoking cessation. Data showed an 81% uptake for cervical smears.

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data available to us showed that the practice was achieving about 92.2% coverage for the DTaP / Polio / Hib Immunisation (Diphtheria, Tetanus, acellular pertussis (whooping cough), poliomyelitis and Hemophilus influenzae type b) vaccination for the 12 month age group children, which was at par with the CCG average. For Meningitis C coverage was 81.1% (CCG-79.5%) and for Pneumococcal Conjugate Vaccine (PCV) 92.2% (CCG-92.2%), MMR coverage for the 24 month age group was 86.5% (CCG-90.0%). There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with on the day of our visit told us that they were treated with kindness and respect both by doctors and nurses and by the practice reception staff. We received 12 comment cards from patients who attended the practice during the two weeks before our inspection and almost all were complimentary of the care they received from the surgery staff.

The 2013/14 GP survey results (latest results published in July 2014) showed that 95% of respondents had confidence and trust in the last GP they saw or spoke to (compared with a Lambeth CCG average of 91%). Seventy four per cent of the respondents said that the last nurse they saw or spoke to was good at giving them enough time (Lambeth CCG average of 72%).

We reviewed the most recent data available for the practice on patient satisfaction. The 2013/14 GP survey results (latest results published in July 2014) showed that 94% of respondents said the last GP they saw or spoke to was good at listening to them and 93% of respondents had confidence and trust in the last GP they saw or spoke to. Ninety two per cent of the respondents said that the last GP they saw or spoke to was good at giving them enough time and 91% found the receptionists at the surgery helpful.

We also spoke with five patients on the day of our visit. They stated that the GPs were caring, and that they were treated with dignity and respect.

The practice phones were located and managed at the reception desk. As mentioned, the surgery was not purpose built and amongst other shortcomings had limited waiting room area with seating for patients close to the reception desk. We were shown the business plans that had been approved for re-location and the practice, we were told, would be moving to a new location in 2016. Staff we spoke with were aware of the need to be respectful of patients' right to privacy and dignity. We noted in our observations that the reception staff made an effort, as much as was possible, to ensure patients' privacy was maintained while on the phone or talking to patients at the reception desk. The practice staff told us that if required they could take calls at the back of the reception area to ensure privacy.

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

Care planning and involvement in decisions about care and treatment

Patients who attended the practice were provided with appropriate information and support regarding their care and treatment. Healthcare leaflets were available for patients, and posters with healthcare information were displayed in the waiting area and consultation rooms. The practice's website provided information about the different services that were available, clinic times, newsletters and the PPG activities being undertaken by the practice. Staff told us that translation services were available for patients who did not have English as a first language.

All five patients we spoke with on the day of our visit were happy and satisfied with the care they received from the practice. They stated that the GPs were caring and listened to them and they felt involved in decisions related to their care and treatment. The 2014 PPG patient survey report found that 94% of respondents felt their GP involved them in decisions about their care, 98% felt their GP explained the proposed treatment and 94% felt their GP addressed any concerns they had.

Patient/carer support to cope emotionally with care and treatment

The GP and the practice manager told us about the support provided to people who had suffered bereavement and that staff could signpost patients to bereavement support and counselling facilities in the community following a death. The staff told us that as it was a small practice they knew their patients well and were very vigilant to the needs of patients who were elderly, vulnerable, had complex conditions or were carers and looking after others. The practice manager told us that in their electronic patient record system they could highlight a patient as a carer so that staff were aware and the patient's needs as a carer were kept in mind.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients' needs were suitably assessed and met and we found the practice to be involved with their Patient Participation Group (PPG). The PPG members were invited to comment on various improvements that were planned in the surgery. For example, the practice recognising the trend on complaints regarding appointment access and took the time to discuss the various models of appointments systems they had researched with the PPG. The PPG then agreed with the practice the model they would pilot from April 2014. The practice also undertook joint working with the PPG to gain approval for the business plans to relocate to a new purpose built surgery in 2016. Various options, business plans, advantages and disadvantages of each location were discussed and made available for patients to consider and provide feedback on.

The practice learnt from patient's experiences, concerns and complaints to improve the quality of care. Feedback from patients was obtained proactively and the service acted accordingly. There were regular meetings attended by the practice manager and one of the GPs. Patient surveys to obtain feedback on different aspects of care delivery were undertaken annually.

The practice had multi-disciplinary meetings with external professionals, such as from the local hospice and the community to discuss the care of patients. Various topics discussed in these meetings included care of end-of-life patients, any deaths of patients on the practice's list, any new cancer diagnoses and also safeguarding issues, significant events, unplanned admissions and A&E attendances. The practice was responsive to the needs of their patients. Reviews of the care records showed that patients with long term conditions such as diabetes, and those with learning disabilities, dementia and mental health disorders received regular medicines review and also an annual review of their care.

The senior partner had completed the training in the National Gold Standards Framework Centre (GSF) in end of life care and there was evidence of close working with a local hospice for the management of care of patients requiring end of life care. The practice used risk profiling which helped clinicians detect and prevent unwanted outcomes for patients. The work associated with the delivery of various aspects of the Directed Enhanced Services (DES) was undertaken suitably and monitored. For example, under the unplanned admissions DES, people had been risk profiled and care plans put in place for those identified as at high risk of unplanned hospital admission to achieve the 2% target. [GPs are contracted to provide core (essential and additional) services to their patients. The extra services they can provide on top of these are called Enhanced Services. One of the types of enhanced service is Directed Enhanced Service (DES) where it must be ensured that a particular service is provided for the population].

Tackling inequity and promoting equality

There were arrangements to meet the needs of the patients for whom English was not the first language. The practice provided care to a local sheltered accommodation whose residents were predominantly of Chinese and Vietnamese origin. The practice was responsive to their needs as was evidenced by a close working relationship with the warden of the accommodation, provision of interpreter services and an understanding of their specific health needs such as in the clinical areas of osteoporosis, diabetes and hypertension.

We were told that longer appointments could be scheduled for patients with learning disabilities. Review of care of people with learning disabilities showed that they were receiving suitable care and had received an annual review within the last year.

Access to the service

The practice had a Personal Medical Services (PMS) contract and provided a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, contraception services and minor surgery.

The practice is currently open five days a week from 8:00am to 6:30pm. In addition, the practice offers extended opening hours from 6:30pm to 8:00pm every Monday and one Saturday every month from 9.00 am to 12.00 pm. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to out-of-hours service when the surgery is closed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice maintained a user-friendly website with information available for patients on services provided, home visits, health promotion, obtaining test results, joining the PPG, PPG minutes, meeting agendas, booking appointments and ordering repeat prescriptions.

Appointments could be booked by phone, online and in person. Staff said that under five year olds were given a priority and would be seen or contacted by the GP within the day. All the patients we spoke with were happy with the appointments system currently in place. They said appointments were easy to get and were available at a time that suited them. We looked at the booking system to check for availability of appointments and saw that routine appointments with GPs were available within 48 hours and those with the healthcare assistant available for the next morning. The 2014 PPG survey though had received mixed comments with some patients commenting on the difficulties in booking appointments in advance. Some patients found the online booking facility very useful, whereas others felt it had only served as a token effort.

Information was available via the answer phone and the practice's website, providing the telephone number patients should ring if they required medical assistance outside of the practice's opening hours.

The premises was an old converted Victorian building and there were long corridors and narrow staircases and the consultation and treatment rooms were on two floors. The premises, with its limitations was however able to meet the needs of patients with disabilities. The ground floor had a consulting and treatment room and patient toilets, which were all wheel chair accessible. Staff ensured that patients with mobility difficulties were greeted and received at the door and booked to be seen in the downstairs room. An entrance ramp was available for patients who used a wheelchair.

Listening and learning from concerns & complaints

The practice had effective arrangements in place for handling complaints and concerns. The practice had a complaints handling procedure and the practice manager was the designated staff member who managed complaints.

The practice also had a system in place for analysing and learning from complaints received in the practice. The practice reviewed complaints on an annual basis to detect any emerging themes. Review of an example of a complaint and the annual report showed that actions were taken to follow up on the initial complaints including responding to and discussing the concerns with the complainants. Wherever possible suitable action had been taken to help improve the service. For example, in one case where a complaint had been raised about the patient not receiving a call-back from the GP, we noted that the issue had been discussed and learning incorporated to improve the system.

Are services well-led?

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

Our findings

Vision and Strategy

The surgery had a practice charter and a statement of purpose which outlined the practice's aims and objectives and laid out patients' responsibilities as well as their rights. All the staff we spoke with described the culture as supportive, open and transparent. The receptionists and all staff were encouraged to report issues and patients' concerns, to ensure those issues could be promptly managed. Staff we spoke with demonstrated an awareness of the practice's purpose and were proud of their work and team. Staff felt valued and were signed up to the practice's progress and development.

Governance Arrangements

The practice had good governance arrangements and an effective management structure. Appropriate policies and procedures, including human resources policies were in place, and there was effective monitoring of various aspects of care delivery. We looked at a sample of these policies which were all up to date and accessible to staff.

Staff were aware of lines of accountability and who to report to. The practice had regular meetings involving GPs, practice manager and receptionists. Meeting minutes showed evidence of good discussions of various issues facing the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

There was a culture of learning and auditing and a number of clinical audits had been completed to ensure compliance with national guidelines and to improve the practice.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

The practice was led by the three partners and a practice manager. Discussions with staff and meeting minutes revealed team working and effective, inclusive leadership. There was a clear leadership structure which had named members of staff in lead roles for dealing with complaints, medicine management, personnel, long term conditions, safeguarding and QOF. We spoke with nine members of staff and they 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. We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Practice seeks and acts on feedback from users, public and staff

We found the practice to be involved with their patients, the Patient Participation Group (PPG) and other stakeholders. There was evidence of regular meetings and PPG members' involvement in undertaking patient surveys. The practice was engaged with the local CCG, the local network and peers. We found the practice open to sharing and learning and engaged openly in multi-disciplinary team meetings.

We found evidence that the practice responded to feedback from patients as was evidenced by the changes made to availability of telephone appointments. The practice manager showed us the analysis of the last patient survey which was conducted in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

Staff were supported in their professional and personal development and staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

The practice had systems and processes to ensure all staff and the practice as a whole learnt from incidents and significant events, patient feedback and complaints and, errors to ensure improvement. The GPs provided peer support to each other and also accessed external support to help improve care delivery.

Are services well-led?

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

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