The Practice Furzedown

Quality Report

88E Eardley Road, London, SW16 6BL
Tel: 020 8677 0083
Website: **www.thepracticegroup.co.uk**

Date of inspection visit: 19 March 2015
Date of publication: 16/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Furzedown Practice on 19 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective, and well led services. It also required improvement for all population groups because of the overall rating. It was good for providing a caring and responsive service.

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.
- The practice had not been monitoring fridge temperatures appropriately in terms of taking action and escalating matters when the minimum or maximum fridge temperatures were exceeded. Vaccines were therefore not being stored appropriately, within cold chain guidance. Urgent appointments were usually available on the day they were requested.
- The practice had a number of policies and procedures to govern activity.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Significant events were recorded as incidents and there was no appropriate analysis of significant events that had been recorded.
- Information about services and how to complain was available and easy to understand.

The areas where the provider must make improvements are:

- Ensure vaccines are stored appropriately and appropriate action is taken when fridge temperatures exceed minimum and maximum temperatures

Summary of findings

- Ensure staff have received appropriate training for medicines management, particularly in relation to the safe management of vaccines..
- Ensure there are formal governance arrangements in place and staff are aware how these operate.

The areas where the provider should make improvements are:

- Ensure that significant events and incidents are recoded appropriately
- Undertake Structured clinical meetings to discuss high risk patients identified from practice systems
- Improve processes for ensuring correspondence received is scanned onto the electronic patient record system in a timely manner to reduce risk
- Ensure all patients with long term conditions, learning disability, those with mental health conditions and vulnerable groups receive an annual review and have access to care planning.
- Establish ways to improve health promotion and uptake of chlamydia, bowel cancer and breast cancer screening in the practice population
- Improve processes for coding clinical conditions and practice activities to improve performance data
- Ensure all patients aged 75 and over have a named GP
- Provide opportunities internally for clinicians to learn and develop through peer support (e.g. regular clinical meetings, updates).

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Safety alerts were disseminated to staff and acted on if required. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when we reviewed the incident log there were some incidents which should have been classified as significant events and were not.

Staff demonstrated awareness of safeguarding issues and all clinical staff had received the appropriate level of child protection and adult safeguarding training. There was a GP safeguarding lead and all staff were aware of who to report to.

Although risks to patients who used the service were assessed, the systems and processes to address risks through medicine management were not implemented well enough to ensure patients were kept safe. This was because we found that fridge temperatures were consistently above the maximum temperature and action was not taken when this had occurred.

Appropriate arrangements were in place to deal with emergencies and major events, including having access to oxygen and an automated external defibrillator.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. There was some evidence that patients' needs were assessed and care was planned and delivered in line with current legislation; however annual reviews and joint care planning were below the QOF targets. Staff had a clear understanding of consent.

There was some evidence of completed clinical audits with limited improvement of patient outcomes. Performance data showed patient outcomes were at or below average for the locality. Health promotion was occurring opportunistically at the practice; however data showed the practice was below average for some areas. Multidisciplinary working was taking place with infrequent formal meetings.. Staff had adequate skills and training to provide an effective service for patients.

Summary of findings

Are services caring?

Good 

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

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. 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place, with patients being updated when complaints were resolved.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and all staff was aware of this and their responsibilities in relation to it. The leadership structure was not clear and although most staff felt supported by management, at times they weren't sure who to approach with issues. The practice had a number of policies and procedures to govern activities which were reviewed regularly. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions and all staff had received regular performance reviews and attended staff meetings and events.

There was a lack of management structure to ensure learning and improvements for clinicians. For example, staff told us there was little opportunity for clinicians to meet and go through learning from events or discuss difficult problems they may encounter. We saw little evidence of support that was offered by the head office and regional lead for the practice in the absence of a permanent clinical lead GP.

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

Requires improvement

The practice is rated as requires improvement for the population group of older people.

The concerns which led to these ratings apply to everyone using the practice, including this population group.

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. They were proactive in directing patients to relevant services such as social services and other voluntary organisations. We saw that where appropriate, referrals were made to occupational therapy and other multidisciplinary services to help patients live safely in their homes and maintain their independence.

The practice had 179 patients aged over 75 years forming 5.3% of their patient population. There was a named GP for patients in this group and 147 patients had been written to, to notify them.

All patients in this population group were offered the annual flu vaccination. This was via specific clinics and offering vaccinations opportunistically. The practice participated in the shingles programme and invited all patients aged 78 and 79 for the shingles vaccination.

The practice offered longer appointments and home visits (if they had mobility problems) for patients in this population group. They ensured appointments were made available to patients in this group, particularly prioritising older patients with complex needs.

People with long term conditions

Requires improvement

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

The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had disease specific registers for patients with long-term conditions. All patients on the register had alerts on their

Summary of findings

clinical records that acted as a prompt to clinicians when these patients required reviews. The registers of patients with long-term conditions were reviewed on a monthly basis and patients' were invited for annual reviews; however take up was very low.

The practice held joint clinics and worked closely with the specialist nurses for diabetes, respiratory and heart failure. Asthma clinics were held within the practice by qualified asthma nurses and patients requiring spirometry were seen by a nurse who had received spirometry training.

Management of patients with long-term conditions was shared amongst clinicians. Nursing staff also 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. However, not all these patients had a named GP, a personalised care plan or structured annual review to check that their health and care needs were being met.

All patients with long-term conditions were offered the flu and pneumococcal vaccinations.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with the CCG averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors

The practice held a joint clinic for antenatal care. Postnatal checks were carried out at eight weeks at the same time as the baby's first check-up.

Children under five were prioritised for appointments and always given on the day appointments, irrespective of whether the parent deemed the issue to be an emergency.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement 

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

The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended hours were offered every day and the practice also opened on Saturdays, which enabled patients who worked to have flexibility in arranging appointments. The practice was proactive in offering online services. A range of health promotion and screening that reflected the needs for this age group were available; however take up of screening particularly bowel cancer was low.

People whose circumstances may make them vulnerable

Requires improvement 

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. We saw that they worked closely with the local authority homeless persons unit to ensure patients experiencing homelessness were supported and their health needs continued to be met. There were 11 patients on the learning disability register. At the time of our inspection only five patients had been offered a physical health check in the last 12 months. It offered longer appointments for people with a learning disability.

The practice participated in the violent patient enhanced service [enhanced services are services which require an enhanced level of service provision above what is required under core GMS contracts]. The practice gave numerous examples of working with a diverse range of patients including those with language barriers and dementia. One of the GPs we spoke with discussed how they are sensitive to cultural values, and discussed risks of female genital mutilation with relevant patient groups.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients how to access various support groups and voluntary organisations. Most staff knew how to recognise signs of abuse in vulnerable adults

and children. Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia).

The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were 49 patients on the mental health register. Only 28 (64%) of people experiencing poor mental health on the mental health register had an agreed care plan which had been reviewed in the last year. There were eight patients on the dementia register. Four of these patients had a care plan in place which had been reviewed in the past 12 months. They offered one hour long appointments to ensure that all their long term conditions assessments were completed and care planning could be completed.

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.

The needs of people experiencing poor mental health were met with service such as offering longer appointments for those that needed them, flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may this stressful

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. Most staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

We received 56 completed CQC comment cards and spoke with nine patients during the inspection. Generally patients were happy with the service they received. Patients described staff as helpful and caring and providing a good service. Many described GPs as good listeners and said reception staff were usually friendly. We reviewed over 80 comments on NHS Choices and around 50% were negative about reception staff and said they found them unhelpful. Some patients we spoke with stated that staffing had changed and recently things had improved.

The majority of patients we spoke with felt it was not difficult getting through to the practice on the phone and fairly easy to get an appointment. However some patients did comment that getting an appointment with their named GP could be difficult, however if patients didn't mind which GP they saw, then getting an appointment was easier. Patients we spoke with generally felt that waiting times were appropriate and they did not have to wait excessively long.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure vaccines are stored appropriately and appropriate action is taken when fridge temperatures exceed minimum and maximum temperatures
- Ensure staff have received appropriate training for medicines management, particularly in relation to the safe management of vaccines..
- Ensure there are formal governance arrangements in place and staff are aware how these operate.

Action the service SHOULD take to improve

The areas where the provider should make improvements are:

- Ensure that significant events and incidents are recoded appropriately
- Undertake Structured clinical meetings to discuss high risk patients identified from practice systems
- Improve processes for ensuring correspondence received is scanned onto the electronic patient record system in a timely manner to reduce risk
- Ensure all patients with long term conditions, learning disability, those with mental health conditions and vulnerable groups receive an annual review and have access to care planning.
- Establish ways to improve health promotion and uptake of chlamydia, bowel cancer and breast cancer screening in the practice population
- Improve processes for coding clinical conditions and practice activities to improve performance data
- Ensure all patients aged 75 and over have a named GP
- Provide opportunities internally for clinicians to learn and develop through peer support (e.g. regular clinical meetings, updates).

The Practice Furzedown

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, CQC inspector and an expert by experience. Add phrase re they have the same authority.

Background to The Practice Furzedown

The Practice Furzedown provides GP primary medical services to 3017 patients living in the London Borough of Wandsworth.

The practice profile for female patients aged between 25-44 is above the England and Wandsworth CCG averages. The practice profiles for male patients aged 25-35 are also above the England and Wandsworth CCG averages.

The practice facilities include five consulting rooms for GPs and two for nurses, wheelchair access, a disabled lift, step-free access and a disabled toilet.

The practice is a part of a corporate company called The Practice Surgeries Limited. A nurse practitioner is the current clinical lead; although the practice had recently offered the permanent vacancy to a GP who was due to join in a few months. There are two female GPs who both work part-time, one female nurse, one female health care assistant and six reception staff. To ensure all sessions are covered, the practice uses a pool of locum GPs. The nurse practitioner is also the practice manager. The practice holds an Alternative Provider Medical Services (APMS) contract. (APMS provides the opportunity for locally negotiated contracts allowing medical services commissioners to contract with non-NHS bodies, such as voluntary or commercial sector providers, to supply enhanced and additional primary medical services.)

The practice has opted out of providing out of hours (OOH) services to their patients. If patients require advice or assistance out of hours they are directed to the 'NHS 111' service for healthcare advice. The provider did not have alternative arrangements in place with an appropriate alternative out of hours' provider.

The practice is registered with the Care Quality Commission to provide the regulated activities of family planning; treatment of disease, disorder and injury; surgical procedures; diagnostic and screening procedures and maternity and midwifery services.

The practice is open from 8.00am to 6.30pm Monday to Friday. The practice offers extended hours from 7.30am to 8.00am and 6.30pm to 7pm on Mondays and Thursdays; 6.30pm to 8.30pm Tuesdays; 6.30pm to 7.00pm on Wednesdays and Fridays; and 8.00am to 1.00pm on Saturdays. Appointments are available throughout all these times. Appointment slots are 10 minutes each, although patients can book double appointments if they need to discuss more than one issue. Urgent appointments are available on the day and four slots are available in both the morning and afternoon sessions. The practice offers online appointments and repeat prescriptions. The practice also offers home visits to patients who are housebound or have difficulty attending the surgery.

The practice provides a range of services including an asthma clinic, child health and development clinic.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of the 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 loot at the overall quality of the service, and to provide a rating for the service.

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 including information published on the NHS Choices website and the national patient survey 2014. We asked other organisations including NHS England and the Clinical Commissioning Group (CCG) to share what they knew about the practice.

We carried out an announced visit on 19 March 2015. During our visit we spoke with a range of staff (GP's, the practice manager, practice nurse and administration 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 treatment records of patients. We held a meeting with the patient participation group and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

National patient safety alerts were disseminated by the practice manager via email to all practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example the practice had received a recent alert about paediatric pads stating that there was a batch error. This error did not affect the practice but was still circulated to all staff for their information. They also told us alerts were discussed individually amongst relevant staff to ensure they were aware of them.

Learning and improvement from safety incidents

The provider maintained a single log of incidents, near misses and significant events. The log did not distinguish between significant events and incidents but near misses were separated out. We reviewed the record maintained for the past 12 months. During this period there had been 20 reported incidents. Staff used incident forms on the practice intranet and all completed forms were sent to the practice manager. Although not classified as a significant event on the log, we saw that one incident that was a significant event was discussed in the practice meetings. It related to the over prescribing of a particular drug to a patient. We saw that the event was discussed in a clinical meeting in February 2015. Roles of those involved were discussed as well as what went wrong, what went well and what could have been done better. 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.

We tracked two incidents and saw records were completed in a comprehensive and timely manner. Incidents were rated according to severity. However, some incidents were not always recorded appropriately. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

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 we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Only clinical staff carried out chaperone duties. Non-clinical staff were never asked to act as a chaperone.

Medicines management

We checked medicines stored in one of the clinical rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The fridge was locked and there was a cabinet with emergency medication which was locked. Fridge temperatures were checked twice a day

There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. However, the practice staff were not following this policy.

We reviewed the practice vaccine fridge temperature log dating back to October 2014. The records showed that recordings of the maximum fridge temperature were consistently between 9-13 degrees. [In line with guidance vaccines and medications requiring storage in the 'cold chain' should be maintained at a temperature range of between +2 and +8 degrees] For example on the 16 March 2015 it was recorded as 13.2 maximum and the 17 March 2015 it was recorded as 11.5 maximum. There was no evidence of action taken as a result of the high readings.

There was no external thermometer. We discussed with the practice manager, who was also the nurse practitioner and they advised that staff had not made them aware of the high readings. They told us that it was a new fridge and there was a possibility that the thermometer was faulty and the temperature readings were possibly inaccurate (i.e. within range). However, there were no assurances that the fault was with the thermometer. We were therefore not assured that the vaccines had been stored appropriately, within cold chain guidance. We advised the practice manager that they needed to report this issue to Public Health England (PHE) as a matter of urgency. Following the inspection we were advised that this had happened.

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.

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. As a nurse prescriber, the nurse was also able to administer vaccines to patients.

All prescriptions were reviewed and signed by a prescriber before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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.

The practice had a lead for infection control. All staff received infection control training which was updated every three years. We saw evidence that the lead had carried out audits monthly and any improvements identified for action were completed on time. Infection control was discussed during practice meetings on a quarterly basis or sooner if the need arose.

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. For example the nurse told us that they always wore gloves giving injections. There was also a policy for needle stick injuries and staff knew the procedure to follow in the event of an injury. A copy of actions to take in the event of sharps injury was displayed in clinical rooms.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. A company visited every week to check the water temperatures and they carried out regular testing. The last legionella risk assessment was carried out on 13 February 2015 with a review date of February 2016.

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. We saw that testing was last carried out in January 2015. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices for previous years. The head office had recently changed the arrangements for carrying out calibration and a new company had been given the contract. This had resulted in an oversight and testing not being carried out in over 12 months. However the practice manager confirmed that calibration was due to be carried out on 26 March 2015.

Staffing and recruitment

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 criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Our checks of the records confirmed the practice was following their recruitment policy. Locum GPs were used regularly and they were subject to the same checks as permanent staff before they commenced employment. There were processes in place to ensure the checks carried out for locums recruited through the agency were adequate.

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. The rota was drawn up four weeks ahead. Any gaps in staffing were covered by other staff. The practice manager told us that using agency staff was a last resort. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

The senior partner who was also the lead GP had recently left. The practice manager told us that a new GP staff member had been appointed and they were waiting for recruitment checks to go through before they could start. As an interim solution, a matrix of requirements had been drawn up with other staff providing cover for the next two to three months to ensure the smooth running of the practice.

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

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. These included a hand washing audit and dress code audit, monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment checks. 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.

The fire alarm and emergency lights were tested twice a week. Staff would log that they received a call from the central call centre to confirm they had been alerted. We saw records confirming this happened. Fire risk safety checks were completed weekly by a member of the administration team. The check included checking fire exits and escape routes, fire-fighting equipment, fire warning systems and fire prevention hazardous substances (COSHH). We reviewed the paperwork of the checks and saw they had been completed for each week. However, records of December's checks were not on file. Staff assured us that they had been completed and the paperwork was just missing.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at meetings. The practice manager told us that risks were also discussed informally amongst staff. For example, they had discussed medication reviews and the links with diagnosis and the on-going problem to ensure risks were minimised.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff (clinical and non-clinical), they all knew the location of this equipment and records confirmed that it was checked regularly. The practice had a pulse oximeter; however it was not easily accessible because it was located in a drawer in the nurses' room. The practice advised us they would move it to a more suitable location.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

Requires improvement

Are services safe?

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. The plan outlined GPs and staff responsibilities. It covered areas such as loss of access to the building both long and short term, evacuation procedures, loss of computer systems and loss of telephone and electricity services. 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 or a local pharmacy if they needed to store medicines or vaccines in a power failure.

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

Requires improvement

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). For example, we saw evidence from discussions with GPs that NICE guidance for hypertension were being appropriately followed and medical records confirmed this. We also saw that NICE guidelines for acute heart failure were being actively used.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines.

We were told the practice had leads in some specialist clinical areas such as diabetes and safeguarding. The nurse practitioner was the clinical lead for the practice and specialised in diabetes. One of the GPs was the safeguarding lead for the practice, and had a special interest in this area, supporting all members of the practice and attending external meetings related to safeguarding issues. Another of the GPs was the prescribing lead for the practice. A GP we spoke with reported that they completed some long term condition reviews; however this was mainly supported by practice nurses.

The practice had 179 patients registered, over 75 years of age. This formed 5.2% of their total population, which was lower than the national practice average. The practice told us that 82% of these patients had been provided with a named GP. GP practices are contracted to provide every patient registered over 75 years with a named GP. The practice was increasingly using risk stratification tools to identify vulnerable, frail and isolated elderly patients who were at risk of hospital admission. Unplanned admission care plans had been initiated for 47 patients who had been identified by the risk stratification tool as having a high probability of hospital admissions.

At the time of the inspection the practice had identified and coded eight patients with dementia. Six of these patients had a care plan in place and had received an annual review, which amounted to 75% of patients (QOF target is 70% for dementia review)%. The practice manager who was also the nurse prescriber and clinical lead, told us they planned to progress further with identifying patients with dementia and providing assessments to identify their needs. They had a plan in place to call patients into the practice monthly or visit them at home for a review and planning of their care. The practice gave an example of using a longer appointment for one dementia patient for one hour, to ensure that all long term condition assessments and care planning could be completed in one session.

The practice kept a register of patients with mental health conditions to ensure care was delivered appropriately, quarterly meetings were held with a Consultant Psychiatrist to discuss patients in their care and a joint care planning exercise was carried out. Sixty four per cent of patients on the register had agreed care plans within the last year.

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 continually review and discuss new best practice guidelines. We were told clinical and non-clinical issues are discussed at the same staff meetings. GPs told us that they have informal case discussions on regular basis and we saw electronic evidence of this via NHS mail.

One GP we spoke with was the lead for prescribing and met regularly with the clinical commissioning group (CCG) pharmacy advisor. The prescribing indicators for 2013/14 indicated that the practice's performance for antibiotic, hypnotic and non-steroidal anti-inflammatory prescribing were comparable to similar practices. The practice had also completed a review of case notes for patients on a contraceptive medication, as part of an audit, which showed all patients were receiving appropriate treatment and regular review with documented risks discussed and alternatives recommended. We saw evidence from discussion with clinical staff and medical records that prescribing guidelines were being applied appropriately. For example, one GP demonstrated use of prescribing guidelines for sinusitis.

The practice informed us that they participated in an enhanced service offered by Wandsworth CCG: the Referral Management Programme. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). This programme provided the practice with clinical expertise and referral

pathway documentation to help inform decision making. All GPs we spoke with used national standards for urgent referrals, for example, suspected cancer patients to be seen within two weeks.

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. The practice participated in the violent patient enhanced service, to ensure equitable access to care. The practice gave numerous examples of working with a diverse range of patients including those with language barriers and dementia. One GP discussed how they are sensitive to cultural values, and had raised awareness of risks of female genital mutilation with relevant patient groups.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, health promotion, referral management and safeguarding. The information staff collected was then collated by the practice manager, administrative and clinical staff to support the practice to carry out audits. We were told that audits were difficult to complete as not all staff were engaged in the process, and we were told that audits were not formally discussed or shared with staff.

The practice had completed a non clinical audit looking at staff understanding and current knowledge level regarding safeguarding processes. Following this, actions were identified from the audit to set up a monthly practice safeguarding meeting with attendance from a health visitor for discussion and sharing of knowledge. The practice had not yet commenced these meetings but had set a goal to initiate this by May 2015.

We saw two clinical audits that had been completed within the last year. One clinical audit was on the use of a contraceptive medication. This audit was completed in January 2014 and re-audited in January 2015. From the initial audit, three patients that were on the medication were provided with an alternative. During the re-audit it was found that more patients had been prescribed the medication in the last year, however for each case, clinical reasoning was evident as risks had been clearly discussed with patients, documented in their records and alternative contraceptive methods offered. Patients however preferred to stay on this medication due to a variety of reasons including improvements in their symptoms. From discussions with clinical staff, the results of this audit had been shared within the practice.

The second clinical audit was for a medication used to treat acid reflux. This was completed in January 2014 and looked at patients with long term use of the medication. We were told that the audit resulted in safer prescribing for patients. The recommended action was to ensure all patients were reviewed and prescriptions were classed as acute rather than repeats, unless long term use was clinically indicated. To aid re-call for a review, where a high dose had been started, an additional alert was added on the electronic patient record so other prescribers were aware of requirement to review and reduce the dose accordingly. The audit was due for re-audit in January 2015 but there was no evidence that this had been completed.

The practice also measured performance and outcomes for patients by using the information collected for 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 met all the minimum standards for QOF for heart disease, dementia, prescribing and hospital admissions. However, some QOF information indicated that the practice was not meeting their targets for diabetic patients. For example, 59% of 187 patients with diabetes had an annual review, which the practice completed at the same time as a diabetic foot check. The practice offered these opportunistically or called patients to invite them in for a review. One administrative staff member we spoke with reported that they followed up diabetic patients who had declined a review where alerts were seen on the computer system. It was felt by staff we spoke with that the data may not reflect the number of reviews they have completed, due to inconsistencies with inputting codes onto the practice patient computer system, to indicate that reviews have been carried out.

The practice advised us that they checked the practice register monthly for each long term condition and invited patients in to the practice for annual reviews; however uptake of these annual reviews were poor and there were

Requires improvement

Are services effective?

(for example, treatment is effective)

frequent non-attenders within their practice population. With an aim to improve uptake, were told that where patients had more than one long term condition, for example diabetes and COPD, the practice was identifying these patients and completed a review for both long terms conditions at the same time.

The practice QOF data identified that the practice had below the expected prevalence for chronic obstructive pulmonary disease (COPD). The practice had 21 patients with COPD. Annual reviews were carried out with either with the respiratory specialist nurse or with a practice nurse.

Due to a number of risks identified from poor achievement with QOF targets, we were told that the practice had developed a QOF plan from April 2015, which we were shown. Each staff member had a role assigned to ensure that coding was used correctly on the patient electronic record system, so it accurately reflected the practice performance in relation to QOF targets.

There was a procedure for repeat prescribing in the practice, however some staff reported that the process for repeat prescribing and medication reviews was unclear and patients needing medication reviews were not always alerted on the computer system. Staff told us that repeat prescriptions were either completed online or paper prescriptions were used. Normally a GP would sign or electronically authorise all repeats, however the nurse practitioner also authorised repeat prescriptions when needed. It was not clear from talking to staff whether the practice had a duty system for managing repeat prescriptions. However, the evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. One GP reported they frequently review their patients after an acute prescription before issuing repeat prescriptions.

The practice had achieved and implemented the gold standards framework for end of life care. We saw evidence that the practice had an up to date palliative care register of six patients and we were told that the practice had recently ensured that their electronic patient coding system had been updated. This meant that patients were flagged as being on the palliative care register. The practice had quarterly multidisciplinary meetings to discuss the care and support needs of patients on this register.

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. The practice had looked at QOF patient pathway data for heart failure, peripheral artery disease, antenatal appointments and secondary prevention of fractured neck of femur. Exception reporting was provided to the CCG where there was any deviation from the expected pathway.

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 adults and children, infection prevention and control and moving and handling. Administrative staff had also received conflict resolution and customer services training. Two staff members we spoke with were able to recount drawing on these skills when dealing with incidents involving verbally aggressive patients and relatives.

We noted a skill mix among the doctors, with two having additional diplomas in family planning, and one with a diploma in obstetrics and gynaecology (women's health). All GPs were up to date with their yearly continuing professional development requirements and appraisal and all had been revalidated. (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, for example a practice nurse recently completed a cervical screening update and NHS health check training.

As the practice was one of a number of practices run by the same provider, (The Practice Surgeries Limited), a regional lead GP from another location was supposed to visit monthly to provide supervision with GPs and the nurse practitioner. Some staff felt that there was lack of clinical leadership and support from the provider organisation. At the time of our inspection the practice did not have a permanent clinical lead GP and the nurse practitioner was acting as the clinical lead for the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice used locum staff members including practice nurses and GPs, as per contracts the provider had with a locum network. We saw evidence of the induction pack provided to locum GP staff containing information on referral processes, safeguarding guidance and safeguarding contact numbers. Staff reported some consistency for patients as there was a tendency for regular GP locums to be used.

The practice had previously been a training hub for doctors training to become qualified GPs, but were currently not acting as a training practice due to not have a GP acting as clinical lead or training lead. We saw that the practice did currently have a qualified nurse that was in training to become a practice nurse. We were told that the practice was involved with a scheme between Wandsworth clinical commissioning group (CCG) and South Bank University for developing and training post registration nurses.

The practice reported difficulty providing access to a health care assistant and practice nurse over previous months due to reduced staffing levels of these particular staff. For example, the practice were unable to offer chlamydia screening to patients in the surgery as there were no nursing staff who had the up to date skills and training to offer this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. The practice had good relationships with a physiotherapist who worked on site weekly, and they had access to a psychologist who was also housed within the practice.

The practice did not use a direct electronic pathology request system connecting to a laboratory or imaging request system. Requests were printed off the computer system and handed to the patient. These results were transmitted electronically back to the practice and reviewed by the requesting doctor; however in their absence they were reviewed by another doctor or the nurse. There was an instance identified by the practice in October 2014 where there was a backlog of pathology results that had not been reviewed by a clinician. From a risk assessment shared by the practice, we could see that this was acted on urgently, and the process was reiterated to GPs to file all reviewed results and all un-reviewed results to be cleared within 72 hours.

We discussed with practice staff the procedure for processing correspondence, including letters from the local hospital including discharge summaries, fax or emails from the out-of-hours GP services and electronic summaries from accident and emergency attendances. The process was not fully effective. All correspondence received was collated into paper format and stamped. Letters and reports were then placed in the appropriate tray for GPs to review and these trays were checked daily. After these letters had been reviewed by GPs they were then placed in a tray awaiting scanning onto the electronic patient record system. We were shown that a small number of letters were not passed onto GPs if they were deemed as not having clinically significant information. Staff told us for example, if a letter stated that a patient had not attended a hospital appointment they would not always pass this on to a GP to review. Some staff we spoke with felt that letters were not scanned in a timely fashion and there were occasionally delays before scanned correspondence appeared against the electronic patient record.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any urgent issues arising from communications with other care providers on the day they were received. Administrative staff were familiar with scanning on correspondence deemed as urgent and this was done on a daily basis.

The practice held multidisciplinary team meetings quarterly for patients with complex end of life needs, who were on the practice Palliative Care Register. These meetings were attended by clinical practice staff along with specialist nurses from a local hospice.

The practice also reported they had multidisciplinary team meetings every one to two months for district nursing staff to attend, however these were poorly attended. Patients identified for these meetings were normally via the district nurse caseload. The practice did not routinely have structured internal clinical meetings to discuss high risk patients.

The practice discussed an example of day to day opportunities where they sought to promote multidisciplinary team working. They had concerns about an elderly patient who was at risk without enough support to enable them to remain at home safely. The practice worked closely with social services to ensure as far as possible that the patient was provided with assistance that day, in order to prevent harm to the patient and prevent an

Requires improvement

Are services effective?

(for example, treatment is effective)

avoidable admission to hospital. The practice also told us they referred to occupational therapy for aids and adaptations to allow patients to live independently at home. Wandsworth CCG use a virtual community ward system, whereby a GP, district nurse and physiotherapist have access to their electronic patient record system and the practice engage with this team to support vulnerable patients in the community.

The practice also discussed an example where they made an urgent referral to local Child and Adolescent Mental Health Services (CAMHS) colleagues where a young person had been identified as at risk whilst at the practice.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also used an electronic incident reporting process and all staff were trained in its use. Policies and procedures were accessible on practice computers, and these were available to other practices run by The Practice Surgeries Limited.

The practice told us that there were inconsistencies with inputting coding onto the electronic patient record system by all staff, which may have affected the performance data for the practice. The nurse practitioner had identified this and had developed a plan from April 2015 to improve consistency across the practice team by training and delegating specific areas to staff. We saw the QOF allocation and recovery plan that had been developed by the practice manager.

The practice used several systems to communicate with other providers. Electronic systems were in place for making referrals; however we were told the practice would only refer a small percentage via the electronic Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice had a process for referring on to secondary care and community services. Letters were processed by administrative staff and either sent via Choose and Book or posted. All letters sent were recorded on a referral log sheet and a daily GP referral summary slip, which were cross referenced. All urgent two week referral letters were faxed and a confirmation of referral was chased by the practice and once received, a read code was put on the electronic patient record system. In addition, all urgent faxes were kept and checked weekly. The choose and book system was also checked weekly to see if patients had been offered an appointment, and the practice followed up patients with a phone call who had not booked ahead. The staff involved in this process felt it worked well and reported no incidents where referrals had been missed. We were told that the practice audited the referrals sent monthly and the number of routine and urgent referrals were calculated.

The practice did not have a process for receiving confirmation for routine referrals, but gave patients advice to alert the practice if they had not had an appointment within a specified time frame. Practice staff reported they had received complaints regarding routine referrals being lost by secondary care systems and they had resent referrals a number of times to ensure the referrals were processed correctly.

The practice had signed up to the electronic Summary Care Record and there was information about this for patients on the practice website (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). A staff member also told us about the awareness campaign the practice was running to promote use of online services for patients to be able to access medical records online, and to encourage patients to sign up to electronic repeat prescribing.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with demonstrated a clear understanding of the issues relating to consent and understood the key parts of the legislation and were able to describe how they implemented it in their practice. One GP we spoke with recently completed update training on the mental capacity act and Gillick Competencies and Fraser guidelines and demonstrated understanding of these.

During the inspection, we witnessed an administrative staff member acting on concerns regarding a vulnerable patient with dementia, in terms of risks to the patient at home and whether the patient had capacity to make decisions about their care. The staff member flagged the concern up

straight away to the lead GP for safeguarding. This demonstrated a culture in the practice of a good understanding of safeguarding and mental capacity issues and a clear process for raising concerns.

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. However, not all patients with a learning disability and dementia had received an annual review to ensure these care plans were updated.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted that the GPs and nursing staff opportunistically used their contact with patients to help maintain or improve mental, physical health and wellbeing. A GP showed us a patient record where opportunistic health advice had been offered during their consultation. Other examples included practice nursing staff offering opportunistic weight management advice and smoking cessation advice.

The practice also offered NHS Health Checks to patients aged 40 to 75 years and we saw posters in the practice alerting patients to this. However, practice data showed that only 79 health checks had been completed so far in 2014/15, which was 6% of patients in this age group. In 2013/14, 78 health checks were completed which was 6% of the target patient group. This showed a consistently low uptake. The practice reported that they were looking to try and improve uptake by advertising health checks on their website, contacting patients by text message or letter and by ensuring all staff continue to offer the health checks opportunistically.

Nursing staff promoted weight management schemes. Eligible patients were identified during the NHS health check, and they were then seen monthly by a member of the practice nursing team for checks and dietary advice and referred to the exercise referral scheme in Wandsworth.

The practice identified patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and practice records showed that 5 out of 11 patients on this register had been offered an annual physical health check in the last 12 months. The practice had also identified the smoking status of 94% of patients over the age of 16 and 90% of patients with long term conditions had their smoking status recorded. Fifty nine per cent of those who smoked had been actively offered smoking cessation advice and offered support via Wandsworth "Stop Smoking" service. The practice reported that there had been five successful quitters from smoking.

The practice's performance for cervical smear uptake was 73.2%, which was lower than the national average of 81.89%. The practice nurses had recent training in cytology. The practice had been actively trying to promote cervical screening by calling patients, offering weekend clinics specifically for improved access to cervical screening, and recruiting agency nursing staff to assist with these clinics.

The practice reported they did not currently offer chlamydia screening to patients in the practice as nursing staff had not received the updated training to provide this. At the time of our inspection there were no planned dates for this updated training to be carried out. Although the practice were liaising with Public Health Wandsworth for this to be arranged. Between October to December 2014 46% of patients offered bowel cancer screening had taken up this opportunity and 69% of patients offered breast cancer screening had attended for checks, however the practice reported that although they opportunistically promoted bowel and breast cancer screening in eligible patients, they were not actively promoting these services to patients. We were told it was previously part of the practice culture to send letters to patients, encouraging them to have screening checks; however this had not occurred for some time. The practice reported they were considering doing this again in the future.

The practice was not a yellow fever centre, but they offered the full range of other travel vaccinations. The practice actively promoted the uptake of seasonal flu vaccinations. For example, as well as opportunistic flu vaccinations, they provided walk in clinics, printed flu reminders on prescriptions, visual advertisement using promotional material including banners and t-shirts. The practice also participated in the shingles vaccination programme and offered this to eligible patients at the same time as the seasonal flu vaccination. The practice reported that uptake for seasonal flu vaccinations were low, as patients declined

Requires improvement

Are services effective?

(for example, treatment is effective)

the offer of this. For example, for 2014/15 patients over 65 years who received the flu vaccination were 66% of those eligible. Twenty two per cent declined the vaccination when offered by the practice.

So far for 2014/15, 107 of the 187 identified diabetic patients received the flu vaccination, which is 70%. The practice target for this was 95%. In 2013/14 the practice had a similar uptake.

For 2014/15, 533 patients vulnerable and at risk aged between 6 months and 64 years were eligible for the flu vaccination and only 232 received it.

The practice offered a full range of immunisations for children in line with current national guidance. Practice performance data for 2014/15 indicated that all children aged 2 and children aged 5 had the necessary vaccinations required. Performance data for 2013/14 for those aged 12 months and 2 years was near average for the CCG for all immunisations. The practice provided joint mother and baby post natal checks at eight weeks by the practice nurses and GPs working together to co-ordinate this.

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 national patient survey conducted in 2015 (373 surveys sent out; 103 surveys sent back; 27% completion rate) [The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England; latest results were published on 8 January 2015. The evidence from this survey showed patients who responded were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 79% of patients rated the practice as good or very good. The results of the survey showed that 87% of the respondents had confidence and trust in the last GP they saw or spoke to. Eighty nine per cent of respondents to the national patient survey said reception staff were helpful.

We spoke with nine patients on the day of our visit. They told us that the GPs were respectful and kind and always treated them with dignity. Patients described reception staff as helpful, kind and courteous.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 57 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. Many of the comments related to the practice nurse who patients described as having a caring nature and good listening skills. The majority of patients were satisfied with the care provided by the practice and said their dignity and privacy was respected. We received some negative feedback which related to issues with getting appointments, both advance and urgent.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatment so that confidential information was kept private. We noted that reception staff spoke with lowered voices to minimise the chance of others overhearing conversations with patients. The reception desk had individual booths to enhance confidentiality further. We saw that there was a system in operation during our inspection of minimising the number of patients at the reception desk at any one time. There was an interview room available in reception area if patients required discussions that needed additional privacy.

Notices relating to chaperoning and setting out arrangements were displayed in the patient waiting room.

Care planning and involvement in decisions about care and treatment

The national patient survey results showed that 71% of patients (103 patients completed the survey and 43 respondents answered this question) felt the last GP they spoke with was good at involving them in decisions about their care and treatment, compared to 76% for the CCG average.

The majority of 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. Two patients reported having negative experiences with the GPs, feeling at times their health issues were dismissed by the GP.

Staff told us translation services were available for patients who did not speak English. For example, the practice had a high number of patients from the Somalian community and regularly used translation services so that they ensured patients were involved in decisions about their care and treatment.

Good

Are services caring?

The practice carried out their own annual patient survey. The results from the annual survey conducted for 2014 had not been fully analysed however results indicated that patients generally found the GPs to be helpful and involved them in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Information leaflets about support services were available to patients in the waiting room and on the practice website. Patients we spoke with were aware of counselling services in the area and one patient told us that staff had signposted them to services in the past.

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received indicated that patients felt they received appropriate support to access support services to help manage care when it was needed. For example, they said that that staff responded compassionately when they needed help and provided support when required.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to most 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. However they had identified they were not meeting the needs of patients with long term problems such as diabetes and asthma. This was the result of poor read coding. In response, additional training was planned for read coding for all staff to ensure they had the appropriate information on the system to meet the need and identify patients.

The clinical system was set up with alerts that appeared on patient records to alert staff to respond to patient's needs. This included reminders for patients on repeat medication. For example if a patient's asthma review was due or if they needed to be screened for dementia an alert would appear if a member of staff entered their record. The practice manager told us that administration staff sent out letters to patients when their medication was due to be reviewed.There were 40 patients on a register of people who may be at risk of unplanned admissions to hospital. All these patients had care plans in place and they had been reviewed in the last 12 months to try and prevent unwanted admissions.

The practice manager told us that they worked closely with the local Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example they attended a quarterly Planning All Care Together meeting with the CCG. This meeting was to discuss the needs of the local population. We saw minutes of meetings where the needs of the local population had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

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). For example the PPG members we spoke with told us about a suggestion they made to make alterations to the telephone answering system for Saturdays. They suggested changing the answerphone on Saturdays to make patients aware that the reception area was not staffed. They had also been involved in trying to reduce the number of "did not attend" (DNA's). This had involved raising patients' awareness about the implications of not attending appointments through putting posters in the reception area.

Tackling inequity and promoting equality

The practice had access to online, face to face and telephone translation services. Due to the high number of patients whose first language was not English, these services were used fairly frequently. For example, the practice manager told us that they had a high percentage of Somalian patients. The practice had access to interpreting services to ensure they could communicate with patients who came in for same day or booked appointments.

The practice provided mandatory face to face equality and diversity training to all staff. We reviewed records and saw that this had taken place. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patients with disabilities. This included having disabled toilet facilities and automatic opening doors (although the automatic doors were not working on the day of our inspection). Staff told us there were plans in place for them to be repaired.

The practice was situated on the first and second floors of the building with most services for patients on the first floor. There was lift access available and the waiting area was large enough to accommodate patients with wheelchairs and prams, allowing for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice offered care and support to patients in vulnerable circumstances. For example homeless people were able to register with the practice and be seen by a GP if required. Such patients were set up on the system as "of no fixed abode" and a record created for them.

Access to the service

The practice was open from 8.00am to 6.30pm Monday to Friday. The practice offered extended hours from 7.30am to

Good

Are services responsive to people's needs?

(for example, to feedback?)

8.00am and 6.30pm to 7pm on Mondays and Thursdays; 6.30pm to 8.30pm Tuesdays; 6.30pm to 7.00pm on Wednesdays and Fridays; and 8.00am to 1.00pm on Saturdays. Appointments were available throughout all these times. Appointment slots were 10 minutes each, although patients could book double appointments if they needed to discuss more than one issue. Urgent appointments were available on the day and four slots were available in both the morning and afternoon sessions.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits, how to book online appointments and order repeat prescriptions. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If 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 111 out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to housebound patients or patients who were too ill to attend the practice.

Patients were generally satisfied with the appointments system, although a small number of patients did comment that it was sometimes difficult to get both advance and urgent appointments. Patients confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Results from the National GP survey showed that 59% of patients with a preferred GP usually got to see that GP. At the time of our visit there were only two salaried GPs who both worked part-time and covered a limited number of sessions. The practice manager told us that due to the high number of locums used it was not always possible to accommodate requests for a specific GP, however patients were offered an appoint with a GP if they needed to see one.

The two salaried GPs' were female. The practice used locum GPs to fill the remaining sessions. If the locum GPs were not male then male patients were offered a chaperone, if one was needed. The registered manager also told us that they usually had a male GP on Saturdays and male patients were offered an appointment with this GP.

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. 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. There was a section on their website that outlined how to make a complaint and details of who patients could contact if they wanted further information. There were also posters in reception and forms available to collect from staff. 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 nine complaints received in the last 12 months and found that they were resolved satisfactorily in line with their policy. We saw that details of the complaint were taken and action taken and lessons learnt were documented. One complaint we reviewed related to a prescribing error. We saw that the complaint was discussed with the relevant clinical staff and the patient was contacted outlining the action that had been taken and issue resolved.

We reviewed team meeting minutes and saw that complaints were reviewed as a part of these meetings.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear written vision to deliver high quality care and promote good outcomes for patients. Although the practice was part of a larger organisation the vision was set at a practice level to ensure it was relevant to the practice. We found details of the vision and practice values were part of staff appraisals and included in the form, so all staff were aware and incorporated them to their own personal development.

All the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice meetings and saw that the vision was discussed at team meetings.

Governance arrangements

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 eight of these policies and procedures and staff we spoke with demonstrated an understanding of the policies, such as the confidentiality policy and complaints policy. All eight policies and procedures we looked at had been reviewed annually and were up to date.

Although there were named staff with lead roles, the leadership structure was limited. The permanent GP lead had recently left. A replacement had been recruited and was due to start in the coming months. In the interim period the nurse prescriber was the interim clinical lead. There were only two permanent GPs and both of them worked part-time, meaning that the majority of lead roles were carried out by the practice nurse. We spoke with eight 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.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing below national standards. We saw that QOF data was regularly discussed at monthly team meetings. For example during the March practice meeting they identified that QOF scores were low and they were working towards improving their score particularly in relation to processing hospital letters and smoking outcomes. Actions were set for nurses to call patients directly and get the information they needed over the phone and also raise the awareness of reception staff remember to ask patients opportunistically about smoking status when they attended.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. For example, the mental well-being of staff had been assessed, including administration staff. The risks had been identified and procedures drawn up in the event of a member of staff experiencing abuse or being emotionally affected by work. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings with the practice manager, who was also the interim clinical lead.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the disciplinary procedures, and management of sickness) which were in place to support staff. We discussed human resource issues and saw that staff were handled appropriately and in line with procedure with issues relating to performance management and disciplinary action.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, complaints and comments. We looked at the results of the annual patient survey for 2014. The results had not been fully analysed however we saw that patients were generally happy with the practice. Areas highlighted by patients for improvements included improving access by telephone and being able to speak with staff within desired timescales. We saw that the practice had planned to review the telephone system to improve the availability of telephone slots.

Are services well-led?

Requires improvement

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

The practice had an active patient participation group (PPG) with a membership of approximately 14 patients in the core group. Routinely, approximately seven to ten patients attended each meeting. On the day of our inspection we spoke with two of the members. They told us that the meetings were useful and helped to involve them of the running of the practice. For example they used the meetings to identify areas where patients could benefit from improvements to the service, review complaints to identify trends and assist in breaking down barriers when there was poor communication due to language issues or jargon. The PPG included representatives from various ethnic and age groups that was generally in line with the practice patient population. The PPG met every quarter, usually during the day. The members told us that they had discussed holding meetings in the evening but the suggestion was not favourable to patients.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that all staff had up to date appraisals 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.

There were only two permanent GPs at the practice who both worked part-time. We were told that due to this there was little opportunity for clinicians to meet and go through learning from events or discuss difficult problems they may encounter. However it was hoped that with the appointment of the new GP who was due to be clinical lead, things would improve. There was a regional lead GP in the organisation, who had responsibility for supporting the practice. The support from the regional lead GP was not visible. We were told the lead visited the practice but the visits were not structured and there was no planned programme for visits. The practice did not have any minutes of meetings to demonstrate the support that was given.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risks associated with the unsafe management of medicines by means of having appropriate arrangements for the recording, handling, using and safe keeping of medicines used for the purposes of the regulated activity. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not ensured that formal governance arrangements were in place and staff were not aware of governance structures. This was in breach of Regulation 23 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014