Dr Saravanapalasuriyar Shrikrishnapalasuriyar

Quality Report

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

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Overall summary

Dr Saravanapalasuriyar Shrikrishnaplalsuriyar, also known as Mornington Surgery is located in New Cross, South East London. The practice serves a diverse multi-ethnic population with high deprivation and a high proportion of elderly patients. The practice delivers primary medical services to approximately 4,426 people. It is operated by a GP partner, one salaried GP and two locum GPs (one male and one female), a part-time Practice Nurse, a Practice Manager, an Office Manager and a team of reception and administration staff. The practice supports medical students (Years 1-to five) from a leading London medical school.

Public Health England (2014) Health Profile for Lewisham shows the health of people in Lewisham is varied compared with the England average. Deprivation is higher than average and about 30.5% (17,500) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 6.6 years lower for men and 6.6 years lower for women in the most deprived areas of Lewisham. In 2012, 23.6% of adults are classified as obese.

Before our inspection, we asked other organisations, including NHS England, Lewisham Clinical Commissioning Group and Healthwatch Lewisham to share what they knew about the service with us. We also spoke to a number of organisations who worked jointly with the practice. We spoke to a district nurse, a community nurse, a member of staff at a hostel for patients experiencing poor mental health and a local pharmacist. During the inspection, we spoke with 17 patients who used the practice (including two members of the patient participation group) and we received and reviewed 41 patient comments cards. We carried out an announced visit to the practice which lasted one day.

Patients said they were usually able to access both face to face and telephone appointments relatively easily. Although patients had to wait up to a week or longer if they wanted to see a specific GP, they said they understood why this was the case. A small number said they sometimes had to wait in reception for long periods to see the GP. The practice offered an extended hours service and patients we spoke with valued this arrangement. We saw that staff responded to urgent appointment requests wherever possible. Out of hours, patients could access care through the local SELDOC GP out of hour's emergency service.

The practice was increasingly developing a better understanding of the needs of its patient population. Patient health outcomes (including those for older people, people with long term conditions, mothers, babies, children and young people, the working age populations and those recently retired, people in vulnerable circumstances and people experiencing poor mental health), were being improved.

However, the practice was in breach of a regulation related to the care and welfare of patients.

Other areas for improvement included:

- Learning from incidents and reflective practice
- Routinely responding to adverse feedback from patients via the practice website

We found care pathways in place for patients with long term conditions such as diabetes or high blood pressure. Patient care management included referral to healthcare professionals in both primary and secondary care in a timely way. Patients received safe care and were protected from abuse because staff had a good level of awareness about safeguarding and the practice had systems in place for safeguarding of vulnerable adults and children.

We looked at services for:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Summary of findings

We found these population groups received care that was safe, effective, responsive and caring. Improvements were required to ensure the service was well-led and that all population groups could access the service when they needed to.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were some mechanisms in place to report and record safety, incidents, significant events analysis and allegations of abuse. Some areas required improvement in the monitoring of safety and responding to risks. All fire extinguishers that we saw were out-of-date. Fire extinguishers being out of date, could present a potential risk to patients and staff in the event of a fire.

The practice had in place effective systems to safeguard vulnerable patients from the risk of abuse. Safeguarding adult's and child protection policies were in place. Staff were able to describe the signs of possible abuse and they knew what to do if they had concerns about patients.

Patients were protected from the risks associated with medicines and the systems in place to store and monitor medication were satisfactory. There were satisfactory systems in place to reduce the risk and spread of infection.

The practice did not have a cardiac defibrillator device (A defibrillator is an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart) and managers had not completed a risk assessment to ensure they were taking reasonable steps to prevent harm.

Are services effective?

The practice manager ensured any alerts or best practice updates were disseminated to clinical staff through the practice email system. The nurse said that senior clinicians were always available for support and clinically based guidance if required, to ensure that services were effective.

Audits were limited to 'checking' the current state of a subject, such as, vitamin D use, rather than offering a full critical evaluation of the subject, leading to the dissemination of learning, change in behaviours and constant monitoring and reviewing of arrangements.

The practice had an induction programme in place for all staff working at Mornington Surgery.

Registers were maintained for patients with long-term conditions such as those with diabetes, heart conditions, dementia, stroke, palliative care and hypertension. The practice manager used an on-line tool to identify and highlight patients with long-term conditions on the patient registers.

Summary of findings

There was scope to improve the range and targeting of health promotion information in public areas of the practice. There were good and effective joint arrangements in place with members of the multi-disciplinary team.

The current staffing skill-mix meant there was minimal nursing input, no health care assistant input and no dedicated resource for taking blood tests. Reviewing and strengthening the practices skills-mix would further improve patient outcomes and strengthen the practices future sustainability.

Are services caring?

All of the patients we spoke with and those who completed comment cards before our inspection described the service provided as either very good or excellent. Patients spoke very highly about the extent to which they were treated with respect, dignity and empathy by all staff at the practice. They commended clinicians on their flexibility and compassionate approach.

Patients said they were fully involved in decisions about their care and treatment. They said they were given sufficient time to discuss their concerns during appointments and as a result they felt listened to and valued.

Are services responsive to people's needs?

Patients said they did not experience difficulties getting through on the telephone. Patients confirmed they were able to obtain routine appointments although some said they did have to wait up to a week or more for an appointment if they wanted to see a specific GP. Patients were treated with respect and they told us that staff took account of their personal beliefs, lifestyle and culture. Reception staff cited an example of recording patient wishes and choice on the IT system.

Patients confirmed that they were referred to hospital or other specialist care and treatment in a timely manner and they were given a choice about where they wanted to receive their treatment.

Language-line interpretation and translation information services were used to ensure that people's language needs were addressed.

Complaints and concerns were effectively managed, however, there was scope to improve further. The practice had not received any complaints since October 2013 and this may indicate the need to further raise patient awareness about how to complain. Verbal complaints were not routinely recorded and on-line complaints were not routinely responded to, so the practice was missing opportunities to respond to patient concerns.

Summary of findings

Are services well-led?

The practice had a written statement of purpose which briefly set out, the aim of the practice. This focussed on prevention of disease, promoting health and improving the social wellbeing of the local population. The document also placed emphasis on treating patients with dignity and respect. However, the practice did not yet have in place a set of practice-wide objectives, setting out what the quality standards for the practice were, when and how these would be achieved, what success would look like and how standards/ objectives would be monitored and reviewed and service improvements made as a result.

The practice had in place a number of support systems for staff, including team meetings (where all staff attended) and separate reception staff meetings with the practice manager. The lead GP had overall leadership responsibility for the practice and they also acted as the registered manager under the Health & Social Care Act 2008.

There was scope to develop audit arrangements further to include a full evaluation of different subjects, leading to the dissemination of learning, change in behaviours, improving patient outcomes, evidence of standards or changes suggested and constant monitoring and reviewing of arrangements.

Arrangements were in place to ensure that patient views were captured and acted upon. These included a Patient Participation Group (PPG) and use of an annual patient survey. The practice had some work to do to better understand its patient's experience. We received positive feedback about the practice, from both patients and providers. However, most commentary on the NHS Choices website was negative. Staff said they felt engaged in the running of the practice.

Some elements of systems to identify and manage risk to improve quality were in place, but some improvements were required. Staff described the practice as having a transparent and open culture, however, there was only limited evidence that the practice actively encouraged the identification of risks and learning lessons from incidents.

Summary of findings

The six population groups and what we found

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

Older people

The practice provided safe, effective, responsive, caring and well led services for older people. Patients told us they were very satisfied with the service provided and they felt that all staff were responsive, caring and treated them with dignity and respect.

Collaborative care plans were in place for increasing numbers of older people, ensuring that patient's needs were identified, relevant multi-disciplinary support was in place, and care was effectively coordinated. Following assessment, where a potential mental health concern, for example dementia, was triggered for an older person, the patient was asked if they wanted to be referred to the memory clinic. This helped ensure that patients maintained choice and control about their care and treatment.

The building was wheelchair accessible and there was a hearing loop for patients who were hard of hearing or deaf.

People with long-term conditions

The practice provided safe, effective, responsive, caring and well-led services for patients with long-term-conditions. We spoke with many patients who were living with a long-term-condition such as diabetes or hypertension. They told us that they were satisfied with the care and treatment they received. Patient comment card feedback was also positive.

The practice's Quality and Outcomes Framework scores for long-term-conditions were adequate. (QOF is the annual reward and incentive programme detailing GP practice achievement results.) For most conditions including lung diseases, cancer, dementia, hypertension and stroke, the practice scored between 97-100%. The exception to this was the practices (QOF) score for diabetes which was 85%. In particular, this had an adverse impact on patients from Black and Minority Ethnic (BAME) communities who had a high prevalence in the figures for diabetes. The practices own data showed that African patients on the practice patient-list were particularly affected by diabetes. There was more for the practice to do to ensure that scores for diabetes improved.

Mothers, babies, children and young people

The practice provided safe, effective, responsive, caring and well-led services for mothers, babies and young patients. Patients that we spoke with told us the service was responsive and they were able to obtain an appointment, when they needed it. Patients said that the

Summary of findings

practice responded in a timely way, to requests for appointments for young children and babies. Staff described an instance where a mother with a small child had been signposted to Accident and Emergency (A&E), without being seen by a GP first. As a result of this incident mothers, babies and young children were now viewed as a priority patient group.

Expectant mothers were offered antenatal and post-natal care from the practice working in collaboration with community midwives to provide support to pregnant women during and after pregnancy. The practice had achieved the 80% QOF target for smear tests. The Quality and Outcomes Framework scores (QOF) showed that the practice had reached the target of 90% for primary and pre-school boosters.

The working-age population and those recently retired

The practice provided safe, effective, responsive, caring and well-led services for working age people (and those recently retired). Patients we spoke with were satisfied with the appointment system at the practice.

The practice opening hours provided working age patients a degree of flexibility as opening times varied. GPs offered an extended hours service one evening a week. Between 12:00hrs-13:00hrs each day, GPs offered telephone consultations.

People in vulnerable circumstances who may have poor access to primary care

The practice provided safe, effective, responsive, caring and well-led services for patients in vulnerable circumstances who may have poor access to primary care. The practice said they were aware of one patient who was homeless and fourteen patients who had been formally diagnosed as having a learning disability. They offered a service to patients with drug and alcohol misuse problems and the lead GP had a special interest in drug and alcohol misuse.

People experiencing poor mental health

The practice provided safe, effective, responsive, caring and well-led services for patients experiencing poor mental health. Mental health checks were offered to patients including those with a learning disability over 50 years old. This was helping to identify patients with early signs of dementia. We spoke with staff from a hostel for patients experiencing poor mental health. Staff at the hostel confirmed that patients were well supported by GPs at the practice and they said that patients received effective treatment from GPs their medication was regularly monitored and reviewed.

Summary of findings

What people who use the service say

During our inspection we spoke with a total of seventeen patients who used the practice (including two members of the patient participation group) and we received and reviewed 41 comments cards.

All of the patients we spoke with and those who completed comment cards before our inspection described the service provided as either "very good" or "excellent". Patients spoke very positively about the extent to which they were treated with dignity and respect by all staff at the practice. Some said that the practice was more like a family environment. Most patients that we spoke with said that their family had been registered with the practice for many generations. Patients commended clinicians and non-clinicians alike for their willingness to help flexibility and compassionate approach.

Patients said they were fully involved in decisions about their care and treatment. They said they were given sufficient time to discuss their concerns during appointments and as a result they felt listened to and respected. Patients told us that when they had experienced significant difficulties, for example, where they were caring for someone in end-of-life or where they had experienced a life-threatening illness themselves, they were well supported, particularly by the lead GP and this in-turn helped them to cope with and manage their ill-health or bereavement more effectively.

Most patients said they would recommend the practice to friends and family and some said they had done so.

There was a developing patient participation group (PPG). Although still at a relatively early stage of development, the PPG members that we met were very positive about the extent to which their views were listened to and they cited examples of their impact and action the practice had taken as a result of the groups' feedback.

The national GP Patient Survey results for 2014 showed the practice had scope to improve its performance further. For most patient experience questions in the survey, the practice scored lower than the CCG (regional) average.

Areas for improvement

Action the service MUST take to improve

The practice did not have a cardiac defibrillator device (an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart) and managers had not completed a risk assessment to ensure they were taking reasonable steps to prevent harm.

Action the service SHOULD take to improve

There was limited evidence that the practice had in place systematic and coherent arrangements to support an active learning culture, for instance learning from incidents and reflective practice in action.

We heard contradictory evidence about whether urine was disposed of in a hand-washing sink. This presented a potential risk of cross-infection.

The practice had very limited nursing input (4hrs per week) and there were few opportunities for patients to be seen when they wanted to be seen by a female GP or other health care professional. There was no health care assistant input. As a result of the current skill-mix the GPs carried out most blood tests, vaccinations and all new patient registrations.

The practice had not fully exploited opportunities for effective and targeted display of health promotion information in public areas of the practice.

Staff did not routinely respond to adverse feedback from patients via the practice website

Dr Saravanapalasuriyar Shrikrishnapalasuriyar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Lead Inspector and a GP. A Practice Nurse with a specialism in health service management and a Practice Manager were also part of the inspection team.

Background to Dr Saravanapalasuriyar Shrikrishnapalasuriyar

Mornington Surgery is located in New Cross, South East London. The practice serves a diverse multi-ethnic population with high deprivation and a high proportion of elderly patients. The practice delivers primary medical services to approximately 4,426 people. It is operated by a GP partner, one salaried GP (both male) and two locum GPs (one male and one female), a part-time Practice Nurse, a Practice Manager, an Office Manager and a team of reception and administration staff. The practice supports medical students (Years one to five) from a leading London medical school.

The practice is registered to provide the following regulated activities, which we inspected: treatment of disease, disorder or injury diagnostic and screening procedures, family planning, maternity and midwifery services.

The practice is open from 08:00hrs to 18:30hrs Monday to Friday and offers an extended hours service with pre-bookable appointments on a Monday from 18:30hrs and 19:45hrs. The extended hour's service is served by two GPs.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care

Detailed findings

- People experiencing poor mental health.

We carried out an announced inspection over one day on 09 July 2014. The inspection was led by a CQC Lead Inspector. A GP, a Practice Nurse and a Practice Manager were also part of the inspection team.

Before our inspection we spoke with two patients who were registered with the practice and staff from a hostel for patients experiencing poor mental health. We also spoke to a local pharmacist, a community matron and a health visitor, who worked jointly with the practice.

During our inspection we spoke with 17 patients who used the practice (including two members of the patient participation group) and we received and reviewed 41 comments cards. We spoke with all members of staff who were at the practice on the day of the inspection.

Before visiting, we reviewed a range of information we hold about the service. We also asked a district nurse, a community nurse, a manager of a hostel for patients experiencing poor mental health and a local pharmacist to share what they knew about the practice. During our visit, we spoke with all staff that were present that day including two GPs, a practice manager, a practice nurse, an office manager and three receptionists. We observed how people were being spoken to in the reception area and talked with carers and/or family members.

We looked at the practice's policies, procedures and audits which the practice had carried out.

We reviewed information that had been provided to us during the visit and we requested additional information which was reviewed after the visit.

Are services safe?

Our findings

There were some mechanisms in place to report and record safety, incidents, significant events analysis and allegations of abuse. Some areas required improvement in the monitoring of safety and responding to risks. All fire extinguishers that we saw were out-of-date. Fire extinguishers being out of date, could present a potential risk to patients and staff in the event of a fire.

The practice had in place effective systems to safeguard vulnerable patients from the risk of abuse. Safeguarding adult's and child protection policies were in place. Staff were able to describe the signs of possible abuse and they knew what to do if they had concerns about patients.

Patients were protected from the risks associated with medicines and the systems in place to store and monitor medication were satisfactory. There were satisfactory systems in place to reduce the risk and spread of infection.

The practice did not have a cardiac defibrillator device (A defibrillator is an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart) and managers had not completed a risk assessment to ensure they were taking reasonable steps to prevent harm.

Safe track record

We spoke with a total of 17 patients before and during our inspection and received 41 comment cards. All of the comments were very positive about the care and treatment patients received. Patients that we spoke to before our inspection were asked whether they felt the service was safe and all patients said they did.

The practice had a whistleblowing policy and all staff demonstrated awareness of the policy. Staff said they felt sufficiently confident to raise concerns. The practice manager and the lead GP said they routinely had conversations with staff to remind them that if necessary, they could raise concerns with external stakeholders. Staff confirmed that these conversations had taken place.

The practice used a range of different information sources including safeguarding activity, complaints, incidents, audits and feedback from patients using the service to shape and inform its approach to delivering safe patient care. We saw evidence of how all staff were required to sign a document to say they had read national safety alerts received by the practice.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. Staff were aware of the procedure for reporting significant events and of the practice's designated leads for responding to clinical and non-clinical significant events. The practice's log of significant events showed that learning points from each event had been identified and changes made to the practice's systems and processes where required to prevent reoccurrence. Staff told us about one incident where a member of the reception staff had not ensured that a patient presenting at the practice was seen by a GP. Rather than ensuring that the patient was given a GP appointment, staff signposted the patient directly to Accident & Emergency (A&E). The patient presented with an abdominal lump which turned out to be a hernia. The GP would have preferred to have assessed the patient before signposting to A&E. We saw that a significant event analysis (SEA) was completed following this incident and the incident discussed at a team meeting. We were told that mothers, babies and young children were now prioritised for appointments to see a GP.

Reliable safety systems and processes including safeguarding

Systems and processes were in place to minimise the potential for error around issuing prescriptions and repeat prescriptions. Staff has specific responsibility for prescriptions to avoid confusion or error. The computer system alerted staff so they knew when medication and other reviews were due and the practice had developed a system for sending reminders to patients about their reviews, along with their prescription, to support patients to manage their own treatment.

Patients were protected from the risk of abuse because the practice had taken steps to prevent abuse from occurring. The practice had in place up to date policies and procedures to support effective safeguarding of children and adults. The lead GP was the named person for safeguarding children and adults.

We saw evidence that GPs were trained to Level 3 in child protection. The practice nurse was trained to level 2 in child

Are services safe?

protection. Non-clinical staff had received basic on-line training in child protection. In terms of adult safeguarding, all clinical and non-clinical staff had received relevant e learning.

We spoke to the lead GP, reception staff, the practice manager and office manager who were able to demonstrate satisfactory levels of awareness about the types of abuse and what steps to take in the event they became concerned about a patient. We saw that following training, discussions had taken place at staff meetings about the importance of safeguarding children and adults this was helping to strengthen staff awareness.

Before we carried out the inspection visit we spoke to a health visitor who was linked to the practice. The health visitor confirmed that they met with the lead GP on a monthly basis to discuss child protection matters and that these arrangements were effective. We were told that these meetings were also attended by the Clinical Commissioning Group (CCG) child protection lead. The CCG is a member organisation made up of the GPs in the area. The CCG has responsibility for meeting the health needs of the local populations.

A chaperone policy was in place to support and safeguard both patient and clinicians during medical examinations. We saw written information in the reception areas informing patients they could ask for a chaperone. Reception staff said that they had received basic briefing in the role of a chaperone from the lead GP to support them in this role.

Monitoring safety and responding to risk

There were areas for improvement in the monitoring of safety and responding to risks. The red fire extinguishers that we saw were out-of-date. Fire extinguishers being out of date, could present a potential risk to patients and staff in the event of a fire. Despite a recent (29 May 2014) external fire safety assessment recommending that all red fire extinguishers were replaced, at the time of the visit, this had not yet been carried out. The practice said that they would replace all red fire extinguishers, when the matter was brought to their attention. The practice manager carried out annual risk assessments of the building including fire safety audits and health and safety assessments, however these audits had not picked up the fact that the red fire extinguishers needed changing.

The fire alarm was serviced annually by an external contractor and we saw evidence of regular fire-drills being conducted by the practice manager. We also saw up-to-date safety certificates for fire-alarm, gas, electricity and legionella water testing. Staff had awareness of The Control of Substances Hazardous to Health guidance (COSHH) and how this impacted on patient safety.

There was an awareness of risk by all staff and separate information was considered from a range of sources to monitor safety, including complaints, significant events and a small number of clinical audits. However, there was scope for further improvement. There were opportunities to develop a more systematic and coherent approach to support an active learning culture. For instance, more identification of risk, incidents, engaging on-line complainants and evidence of learning from incidents and reflective practice.

Medicines management

Effective medicines management arrangements were in place including those for managing and issuing repeat prescriptions and reviewing medication. We reviewed the practices arrangements for obtaining, recording, handling, storage and disposal of medicines. We looked at how the practice stored and monitored medication, to ensure patients received medicines that were in date and correct. This included emergency medicines and vaccines.

The system in place for ordering and storing vaccines was effective. We looked at the vaccine fridge and it was locked on the day of inspection. We saw that the refrigerator temperature was in-range and was monitored twice daily and recorded in a book. The GPs ordered the vaccines and they had an effective system in place to ensure that only in date vaccines were stored.

Cleanliness and infection control

The practice had an infection control and prevention policy and the lead GP and practice manager had joint responsibility. We found that the premises were visibly clean and tidy in all areas. Most patients that we spoke with confirmed that the building was usually clean and tidy.

We heard contradictory evidence from staff, about whether urine was disposed of in a hand-washing sink or whether urine was disposed of in the toilet. If urine was disposed of

Are services safe?

in a hand washing basin, this would present an area of potential cross-infection. A recent infection control audit was carried out by practice staff but it had not identified this as an issue.

We saw that the practices infection control policy contained arrangements for the management of staff and patients with contagious illnesses. Staff were asked not to attend the practice if they knew they had such a condition and patients attending the practice, waited away from the main waiting room to see the GP.

A cleaning contract was in place with an external company. We saw records indicating the practice was cleaned three days a week. On the day of our visit the premises were visibly clean and patients said the building was generally clean in their experience. Staff said, if there were accidents or spillages, they were responsible for cleaning areas of the building when the cleaner was not working. We saw that different coloured mops/mop-buckets were used for different areas of the building to reduce the risk of cross-infection. A contract was in place with a licensed carrier for the regular removal of clinical and hazardous waste.

The consultation rooms that we checked had newly fitted sinks and easy-clean flooring. Hand gel, soap and paper towels were available at all sinks and there was wall mounted laminated signage about hand-washing. We saw up-to-date safety documentation for legionella water testing.

Staffing and recruitment

The practice had a recruitment policy which set out the process for recruiting clinical and non-clinical staff.

We examined two staff files. We saw that relevant pre-employment recruitment checks were carried out before all staff started employment. This included an application form, references, qualifications and registration with professional bodies. All staff had up to date Disclosure & Barring Service checks (DBS) to confirm their suitability to practice prior to starting employment.

Dealing with Emergencies

A business continuity plan was in place ensuring that the service could be provided in the case of an emergency and protecting patient and staff safety. The office manager had lead responsibility for keeping this up-to-date. The plan was fit-for-purpose and took account of foreseeable emergencies.

The practice did not have a cardiac defibrillator device and managers had not completed a risk assessment to ensure they were taking reasonable steps to prevent harm. (A defibrillator is an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart). Although not mandatory, this equipment was recommended by the Resuscitation Council (UK).

As a result of the current skill-mix the GPs carried out most phlebotomy (blood tests), vaccinations and all new patient registrations. It was not at all clear, what the arrangements would be, in the event that one of the GPs was unavailable for any considerable time.

Equipment

We did not see any evidence of risk assessments carried out by the practice to determine what type of equipment they needed to have in place.

The practice had contracts in place for the maintenance, repair, safety testing and routine recalibration of its medical and electrical equipment to ensure it was fit for use at all times. We saw a range of emergency equipment which was held in the treatment room. We saw there was adequate basic equipment at the practice. There was no defibrillator device in use at the practice. There was one oxygen cylinder and an emergency trolley for use in a medical emergency to transport patients into an ambulance. Audit ensured that only in-date equipment was used. We did not see any out of date equipment.

Are services effective?

(for example, treatment is effective)

Our findings

The practice manager ensured any alerts or best practice updates were disseminated to clinical staff through the practice email system. The nurse said that senior clinicians were always available for support and clinically based guidance if required, to ensure that services were effective.

Audits were limited to 'checking' the current state of a subject, such as, vitamin D use, rather than offering a full critical evaluation of the subject, leading to the dissemination of learning, change in behaviours and constant monitoring and reviewing of arrangements.

The practice had an induction programme in place for all staff working at Mornington Surgery.

Registers were maintained for patients with long-term conditions such as those with diabetes, heart conditions, dementia, stroke, palliative care and hypertension. The practice manager used an on-line tool to identify and highlight patients with long-term conditions on the patient registers.

There was scope to improve the range and targeting of health promotion information in public areas of the practice. There were good and effective joint arrangements in place with members of the multi-disciplinary team.

The current staffing skill-mix meant there was minimal nursing input, no health care assistant input and no dedicated resource for taking blood tests. Reviewing and strengthening the practices skills-mix would further improve patient outcomes and strengthen the practices future sustainability.

Effective needs assessment, care and treatment in line with standards

We spoke with two GP's and a practice manager about how they received updates on best practice such as NICE guidance (National Institute for Health and Care Excellence) relating to best practice or safety alerts. The practice manager ensured any alerts or best practice updates were disseminated to clinical staff through the email system. The nurse said that senior clinicians were always available for support and guidance if required. Where alerts identified the discontinuation of a particular medication, for example, clinicians worked jointly with the practice manager to identify affected patients and to go through patient notes to develop and update individual care plans. As an additional safeguard, the practice manager ensured that all clinicians signed to confirm they had received and read relevant alerts.

The practice manager used a tool to identify and highlight patients with long-term conditions on the registers. This meant that patients care was monitored and reviewed and they were invited in for follow-up. Staff told us that due to the limited nursing input at the surgery most follow-ups were with a GP which impacted on their capacity. There were good joint working arrangements with the community matron and pharmacist to ensue effective patient care.

Management, monitoring and improving outcomes for people

We were told by one GP about a good example where the practice had used audit to manage, monitor and improve patient outcomes. The GP had attended a course about urinary tract infections in men. We saw that on the GPs return, a complete audit cycle had been carried out which allowed the practice to measure their own practice against national guidance. The learning from the training was shared with all other staff and using a systematic approach, patient care was evaluated, adjusted and re-audited on an on-going basis. Other audits that we heard about at the practice, including contraceptive pill and a vitamin D deficiency audit, did not follow a complete audit-cycle.

Quality and Outcomes Framework (QOF) scores showed the practice performed well in regards to follow-up reviews concerning patients with heart failure, chronic heart disease, hypertension and cancer. QOF is the annual reward and incentive programme detailing GP practice achievement results. The practice was well aware of the challenges which remained for them to improve their performance in regards to patients with diabetes. When compared to other practices in the CCG area, Mornington practice was performing better than the CCG average on a number of different data items.

Effective staffing, equipment and facilities

An induction programme was in place for all staff. The practice manager and office manager had collective responsibility for ensuring that staff received effective induction. We spoke to staff that had recently started working at the practice and they confirmed they had received adequate induction. Effective supervision and support arrangements including annual appraisal were in place for non-clinical staff.

Are services effective?

(for example, treatment is effective)

The nurse received day-to-day support from GPs at the practice and they felt that this was effective. However, the nurse did not receive clinical supervision or annual appraisal at the practice where they were employed for a total of four hours.

All GPs received an annual appraisal and they were able to confirm the arrangements for their revalidation. There was evidence of 360 degree feedback being received, including feedback from patients and medical students. All feedback that we saw was positive. GPs said that they routinely discussed clinical matters with each other in their day-to-day work and they felt there was a good level of peer-to-peer challenge amongst clinicians.

All staff received time to support their learning and development. Training records indicated that all staff had completed training relevant for their role and that this was regularly updated. Examples of training completed included, basic life support, infection control, health and safety, safeguarding and information governance. Staff meetings were held on a monthly basis and we saw records of these meetings. Staff said they found the training, team meeting and support arrangements, including the way information was shared, effective. The practice had very limited nursing input (four hours each week) and there were few opportunities for patients to be seen when they wanted to be seen by a female GP or other health care professional. There was no health care assistant input.

Working with other services

Before our inspection we spoke with staff from a hostel for people experiencing poor mental health. We also spoke to a local pharmacist, a community matron and health visitors who worked jointly with the practice. Despite services being stretched due to increasing demand for local community services, there were good and effective joint arrangements in place with members of the multi-disciplinary team.

Health visitors linked to the surgery confirmed they met with the lead GP on a monthly basis to discuss child protection matters. Health visiting staff commended the practice on its flexibility, approachability and responsiveness. There was also a monthly multi-disciplinary team-meeting (MDT), held at the surgery, where patient care was discussed. This meeting focussed on patients with complex long-term-conditions (LTCs). Minutes of the meeting that we saw showed that social care, community nursing, palliative care and district nurse colleagues attended regularly. The community matron took referrals for patients with LTCs including lung conditions, diabetes and high-blood-pressure.

One GP in particular, had an interest and additional training in drugs and alcohol misuse. The practice had 14 patients who required this specialist input and appropriate written agreements were in place to support the work of the GP and other professionals caring for these patients. Hepatitis screening was carried out by the practice throughout the week. GPs contributed to routine meetings involving other local GPs. This was helping to share and disseminate learning and good practice. In time, it was hoped that this forum would provide greater consistency for local patients with comparable needs.

Health, promotion and prevention

The practice had not fully exploited opportunities for effective and targeted display of health promotion information in public areas of the practice. This was important given the health-profile of the local population. For example, there was a high-incidence of sexually transmitted infections in Lewisham and high prevalence of diabetes. There were a number of different leaflets and posters on display, but much of this was not health promotion information. The information on display included stair lifts, obesity, how to book an appointment, safeguarding vulnerable adults and children, carers support and requesting a chaperone. We did not see any leaflets about bereavement support or sexually transmitted infections.

Staff told us they had referred patients to Increasing Access to Psychological Therapies (IAPT) support, but that some patients had experienced lengthy waits for the service. We were told that NHS physical health checks for patients aged over 40 years old were helping to identify patients at risk of diabetes.

The practice was meeting most Quality and Outcomes Framework scores (QOF). The practice had reached the 80% target for cervical screening and for baby and pre-school immunisations they had reached the target of 90% of immunisations. General Practice Outcome Standards (GPOS) data for May 2014 showed the practice performed within the CCG average for flu vaccinations for over 65s. (CCG groups are clinically led groups that include all of the GPs in a geographical area. The groups are set up to deliver local healthcare). Performance for the treatment

Are services effective?

(for example, treatment is effective)

of patients registered and diagnosed with atrial fibrillation and prescribed anti-coagulation therapy was good. The practice showed us data which indicated that 100% of the targets for antiplatelets and anticoagulation had been achieved. Obesity was a health challenge for the practice and staff had identified that 401 of its patient population had a Body Mass Index (BMI) of over 30. (BMI is a measure of a person's weight relative to their height and it gives an approximate measure of total body fat). Of the 401 patients, 40 patients were now being supported by a dietician. The practice reported that many patients had not taken up appointments with the dietician despite staff efforts. Patients had been given dietary advice in consultations with GPs, where the opportunity arose. All of this work contributed to the QOF and supported wider health promotion and prevention of long term conditions.

Are services caring?

Our findings

All of the patients we spoke with and those who completed comment cards before our inspection described the service provided as either very good or excellent. Patients spoke very highly about the extent to which they were treated with respect, dignity and empathy by all staff at the practice. They commended clinicians on their flexibility and compassionate approach.

Patients said they were fully involved in decisions about their care and treatment. They said they were given sufficient time to discuss their concerns during appointments and as a result they felt listened to and valued.

Respect, dignity, compassion and empathy

During our inspection we spoke with 17 patients who used the practice (including two members of the patient participation group) and we received and reviewed 41 comments cards. All patients we spoke with said they were treated with a high-degree of respect, dignity, compassion and empathy by all staff both clinical and non-clinical. The practice performed above the CCG regional average in the national GP patient survey in 2014, compared to other practices when patients were asked if GPs treated them with care and concern. Out of 97 patients who responded to the survey, 86% said the last GP they saw or spoke to was good at treating them with care and concern. Practice performance was also above the CCG average for the last nurse that patients saw or spoke to being good at treating them with care and concern.

Patients that we talked with did not raise any concerns about privacy when speaking to staff at reception. We saw that changes had been made to the reception area to make conversations more confidential. However, the national GP patient survey in 2014 showed that 53% of patients responding were satisfied with the level of privacy when speaking to receptionists at the surgery. This was below the CCG regional average performance.

All patients returning comments to us said that the care and treatment they received from the practice was either "very good" or "excellent". Most of the patients who responded highlighted the kindness and courtesy of staff. Many commented that in particular, they had a high regard for the lead GP.

Where possible, staff sent patients a bereavement card or telephoned them if they knew they were having a particularly hard time. Patients also called the surgery, if they just wanted talk to someone. A number of patients confirmed that they had experienced this level of kindness from staff when they had called or visited the surgery.

Although the practice had no specific expertise in bereavement support, they said they did signpost or refer patients experiencing bereavement or other concerns to local counselling/support services. Patients commended staff at the practice for providing emotional support at times when they most needed it.

Involvement in decisions and consent

The practice had in place arrangements which safeguarded patient involvement in decisions and consent. Staff were trained in the requirements of the Mental Capacity Act 2005 (MCA) and as a result, they were able to describe how they would assess patient's capacity to consent to treatment. Clinicians demonstrated good awareness of consent and Gillick competence requirements. Gillick competence sets out a framework to assess whether a child under the age of 16 years is able to consent to his or her treatment.

Patients said they felt very involved in decisions about their care and treatment. We did not hear about any incidents where patients felt their level of choice and control, over their treatment, was compromised. More than one patient said they had simply turned up on occasion if they needed care and support and they said that staff had received them with a warm welcome. Staff had a good awareness of the requirements for obtaining consent.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Patients said they did not experience difficulties getting through on the telephone. Patients confirmed they were able to obtain routine appointments although some said they did have to wait up to a week or more for an appointment if they wanted to see a specific GP. Patients were treated with respect and they told us that staff took account of their personal beliefs, lifestyle and culture. Reception staff cited an example of recording patient wishes and choice on the IT system.

Patients confirmed that they were referred to hospital or other specialist care and treatment in a timely manner and they were given a choice about where they wanted to receive their treatment.

Language-line interpretation and translation information services were used to ensure that people's language needs were addressed.

Complaints and concerns were effectively managed, however, there was scope to improve further. The practice had not received any complaints since October 2013 and this may indicate the need to further raise patient awareness about how to complain. Verbal complaints were not routinely recorded and on-line complaints were not routinely responded to, so the practice was missing opportunities to respond to patient concerns.

Responding to and meeting people's needs

The Mornington Surgery responded to and met patients' needs and some patients said that staff sometimes went above and beyond, to ensure that patients received care and treatment when they needed it, for example responding to those who had recently experienced bereavement. More than one patient, who had experienced a life-threatening illness or other significant health issues, gave compelling testimony about how effectively and compassionately their needs were responded to by GPs. Patients confirmed they were treated with respect and that staff took account of their personal beliefs, lifestyle and culture. The female practice nurse worked four hours each week and a female locum GP worked one half day a week. As a result, some patients wanting to be seen by a female clinician may not always be able to. Staff were aware of this issue and there were plans in place to address this matter. Reception staff cited an example of recording patient wishes and choice on the front page of the IT system. For example, where patients had particular religious beliefs which meant they might be fasting, for example, at different times of the year.

Patients confirmed that they were referred to hospital or other specialist care and treatment in a timely manner and they were given a choice about where they wanted to receive their treatment. The office manager was responsible for ensuring referrals were made to specialists. We saw how reception staff were using a referral tool/ template, which included the patient's active medical concerns and medication. Reception staff confirmed they currently used "choose and book", but were moving to a new system which would enable more immediate booking of hospital appointments for patients. Reception staff confirmed they received the results of patient assessments, but they also had direct access to Lewisham hospital to obtain results if necessary.

Access to the service

Most patients felt they were listened to and treated with respect both by GPs and reception staff. Patients said they did not experience lengthy waits getting through on the telephone. Patients confirmed they were able to obtain routine appointments although some said they did have to wait up to a week or more for an appointment if they wanted to see a specific GP. The national GP survey results for 2014 showed the practice's performance was above the CCG average, with 84% of respondents saying they found it easy to get through to the practice by phone. This compared well against the CCG regional average of 66%.

The national GP survey highlighted that some patients experienced delays, once they had arrived in the surgery. This was supported by the national GP survey results for 2014 which showed that 32% of respondents usually wait 15 minutes or less after their appointment time to be seen.

GPs offered an extended hours service one evening a week. Between 12-1pm each day, GPs offered telephone consultations. On the day of the inspection, we spoke to patients who had presented at the surgery without a pre-booked appointment and following a wait, they were seen by a GP.

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that during the winter months they provided an open access/walk-in clinic over the lunch period to ease any pressure on the service. Team meeting minutes identified that there had been a discussion about dealing with emergencies at the May 2014 meeting.

Reception staff confirmed that they could offer a sufficient number of appointments routinely, or as an emergency. On-line booking and an on-line prescription service was available and this was helping to increase access for some patients. Staff said that eight appointments were allocated for on-line bookings each week and these were re-allocated, if not booked.

Patients confirmed that they had access to repeat prescriptions in a timely manner, generally within 48 hours if not before. The surgery offered home visits to patients and requests averaged one or two a day.

Meeting people's needs

The practice demonstrated awareness of the needs of the local population and there were arrangements in place for joint working and integrated care pathways, for example, with district nurses, palliative care and community matron services. Good and effective relationships were in place with other providers and we heard about a formal group, recently established within the area, where local GPs had started to talk about opportunities for joint service planning on a more strategic basis.

A telephone interpretation and translation information service was used to ensure that patient's language needs were responded to. Staff spoke a range of different languages, including Tamil, Punjabi, Hindi and Singhalese which also promoted access. The premises were wheelchair accessible via the first and ground floors to the building and there was an accessible patient toilet. A loop system was used to support patients with hearing loss.

Concerns and complaints

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

The practice had in place an up-to-date complaints policy and there were clear procedures for managing complaints. There was a complaints leaflet and patients said this was shared with them. Staff confirmed their approach was aimed at achieving early resolution of concerns. Reception staff explained how they listened to patients to understand their concerns and where necessary they escalated concerns to the practice manager, if they felt they could not resolve the matter immediately. Where appropriate, reception staff asked patients to put their complaint in writing and this was passed to the practice manager. One patient that we spoke to had previously made a complaint and they confirmed the matter was dealt with to their satisfaction and in a timely manner.

The practice had not received any written complaints since October 2013. Adverse comments had been made on the NHS Choices website, but the practice had not engaged with these complainants, to understand what their concerns were and to shape an improvement agenda. Verbal complaints were not routinely recorded, although staff said they did receive them, so the practice was missing opportunities to address patient need and make improvements.

Staff confirmed they had monthly practice meetings where they discussed complaints and significant events. Staff said they reviewed complaints and events and identified what they could have done differently and they tried to learn from these complaints to prevent recurrence. We saw there was a leaflet available to patients about advocacy.

Are services well-led?

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

Our findings

The practice had a written statement of purpose which briefly set out, the aim of the practice. This focussed on prevention of disease, promoting health and improving the social wellbeing of the local population. The document also placed emphasis on treating patients with dignity and respect. However, the practice did not yet have in place a set of practice-wide objectives, setting out what the quality standards for the practice were, when and how these would be achieved, what success would look like and how standards/objectives would be monitored and reviewed and service improvements made as a result.

The practice had in place a number of support systems for staff, including team meetings (where all staff attended) and separate reception staff meetings with the practice manager. The lead GP had overall leadership responsibility for the practice and they also acted as the registered manager under the Health & Social Care Act 2008.

There was scope to develop audit arrangements further to include a full evaluation of different subjects, leading to the dissemination of learning, change in behaviours, improving patient outcomes, evidence of standards or changes suggested and constant monitoring and reviewing of arrangements.

Arrangements were in place to ensure that patient views were captured and acted upon. These included a Patient Participation Group (PPG) and use of an annual patient survey. The practice had some work to do to better understand its patient's experience. We received positive feedback about the practice, from both patients and providers. However, most commentary on the NHS Choices website was negative. Staff said they felt engaged in the running of the practice.

Some elements of systems to identify and manage risk to improve quality were in place, but some improvements were required. Staff described the practice as having a transparent and open culture, however, there was only limited evidence that the practice actively encouraged the identification of risks and learning lessons from incidents.

Leadership and culture

The practice had a written statement of purpose which set out briefly, the aim of the practice. This focussed on prevention of disease, promoting health and improving the social wellbeing of the local population. The purpose placed emphasis on treating patients with dignity and respect. Managers explained how the Quality and Outcomes Framework (QOF) targets were used as the practices key objectives. The practice performance on QOF was good overall

The practice had in place a number of support systems for staff, including team meetings where all staff attended and separate receptionist staff meetings with the practice manager. We were told that reception staff received supervision and annual appraisal from the practice manager. However, supervision sessions were not recorded. We saw written evidence of appraisal of reception staff. The practice manager was supervised and appraised annually by one of the GPs. The practice nurse did not receive supervision at Mornington Surgery where they were employed for 4 hours each week. The nurse received supervision from another practice where they worked many more hours. We saw that a number of policies and procedures were in place including those for bullying and harassment, clinical supervision and equalities. These policies provided a framework for the practices approach to employee relations.

The lead GP had overall leadership responsibility for the practice and was the Registered Manager under the Health & Social Care Act 2008. However, the lead clinician said that decisions were made collectively and that efforts were made to engage and involve staff irrespective of grade. Separately, staff confirmed that there was a team approach to the way decisions were reached and that there was a healthy organisational culture. We saw that clinicians were very supportive of non-clinical staff and there was mutual respect between both parties.

Governance arrangements

Governance arrangements were clear and relevant policies and procedures, including a statement of purpose, set out designated responsibilities. All staff understood and were able to articulate their roles and responsibilities. A clinical governance policy and individual practice policies stated who was responsible for delivery of the policy area. For example, the practice manager and the lead GP had joint responsibility for infection control. The lead GP was the named responsible individual for a number of areas including safeguarding children and adults, Caldicott

Are services well-led?

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

arrangements (a senior person with responsibility for protecting the confidentiality of patient information and information sharing arrangements), information governance and medicines management

Whilst the clinical lead took overall responsibility for decision making, they were able to describe to inspectors how they consistently involved staff in decisions and took account of their individual views. Staff confirmed that they were involved in and could influence relevant decisions.

The statement of purpose described brief aims, but the practice did not yet have in place a comprehensive set of team or practice-wide objectives, setting out what the quality standards for the practice were, when and how these would be achieved.

Systems to monitor and improve quality and improvement

Some elements of systems to monitor and improve quality and improvement were in place, but there were areas for improvement. The practice had carried out some audits including those for vitamin D deficiency and contraceptive pill. As a result, audits that we saw for the most-part focused on numbers, rather than evidence of a full audit-cycle. We also saw how information from safeguarding, risk assessments and significant event analysis were considered.

Positively, we did hear about a good example where a GP had carried out an audit, about urinary tract infections in men, using the knowledge and skills gained on a best practice training course.

The practice did not participate in external peer review and audit. However, the practice contributed to routine cluster meetings involving other local GPs. This was helping to share and disseminate learning and good practice.

Patient experience and involvement

A patient participation group (PPG) had been established for approximately four years. We spoke with three PPG representatives who said they had good and effective relationships with practice staff. They said they felt staff listened to their concerns and they were able to identify actions the practice had taken as a result of feedback from the PPG. The PPG were not able to identify any concerns they had which remained outstanding. As a result of patient feedback there had been improvements to repeat-prescription arrangements and a private 'hatch' had been put in place where patients could talk to reception staff in private.

Before the inspection we looked at patient feedback on NHS Choices website. Despite the positive feedback we received about the practice before and during the inspection, from both patients and partner organisations, most on-line comments we saw were adverse. Patients complained about a range of matters including poor access to appointments, poor levels of dignity and respect afforded to them by receptionists, lengthy waits to see a GP in reception and difficulties obtaining repeat prescriptions. The practice did not respond to these comments online. The national GP survey 2014 showed that the practice's performance was above the CCG regional average, with 76% of patients describing their experience of making an appointment as good.

A patient survey had been carried out by the practice in 2013-14. The PPG identified three key areas to focus on in the survey. The survey included questions about waiting times, patient experience with GPs and comments about the emergency clinic. We saw that 100 patient surveys were given out and 72 were completed and returned within a six week time-frame. As a result of feedback from the patient survey, the practice reported that waiting times had improved. Patient experience with GPs was reported to have been improved and the walk-in emergency clinic was replaced by a book-on-the-day appointment system. Patients that we spoke to and those who completed comment cards raised minimal concerns about the key areas covered in the survey, indicating that progress had been made.

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

The Patient Participation Group (PPG) information board in the waiting room, provided information about how the practice was using patient feedback to improve services and how the practice was feeding back to patients what difference their comments had made. Patient's members of the PPG were able to identify examples of the difference their feedback had made over the past 12 months. For example, a separate window was now available in the

Are services well-led?

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

reception area, where patients could go to talk to receptionists about matters that were more confidential. The PPG had also fed-back comments about the issuing of repeat prescriptions and this too had led to improvements.

We spoke to all staff working at the practice on the day of the inspection, and without exception, staff said there was an effective team approach and staff were engaged and involved in the running and development of the practice. Receptionists said that GPs worked closely with them to ensure that key information about patient care was shared and that safe patient care was consistently delivered. Receptionist said this close working approach with GPs made it easy for them to raise concerns with clinical staff and to establish and maintain an open and transparent working culture.

Management lead through learning and improvement

We spoke with a range of clinical and non-clinical staff and looked at practice policies and procedures. Staff said there was a commitment to learn from feedback, incidents and complaints. We saw some examples of a learning and improvement culture, such as an audit focussed on men with Urinary Tract Infections (UTI) and a vitamin D audit.

Mornington Surgery was a teaching practice which accommodated medical students and this provided the potential to create an environment where challenging discussions could take place which ensured the delivery of best practice and consistently improved patient outcomes. GPs said they regularly shared clinical matters with each other to ensure patients received high quality care and treatment.

Identification and management of risk

The practice manager, office manager and GPs held regular practice meetings and these included reviewing safety and risk incidents and significant events, which had taken place. There had not been any written complaints about the service since 2013 and no issues had been highlighted from their own risk assessments. Health and safety checks carried out by the practice, highlighted low-level risks only, for example, sharps which were kept securely.

There were on-going, checks of the safe running of the practice such as legionella testing, health and safety checks and fire safety.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice provided safe, effective, responsive, caring and well led services for older people. Patients told us they were very satisfied with the service provided and they felt that all staff were responsive, caring and treated them with dignity and respect. Patients told us that in times of bereavement or when they had experienced a life-threatening illness, the practice had been supportive and where possible had offered them referrals to other services such as counselling. We did not hear very much during the inspection about the needs of family carers although the details of carers were recorded on the computer. Where older patients had particular needs, for example, if they were housebound or visually impaired these factors were also noted, so that the practice could be responsive to patient's needs.

GPs worked effectively with members of the multi-disciplinary team including palliative care teams to support patients in end-of-life care. Arrangements for managing the care of end-of-life patients were effective. Quality and Outcomes Framework Scores (QOF) indicated good outcomes for the older patient population. Flu vaccinations were carried out for 286 patients over the age of 65 years in 2013-14. This represented 66% of the total over 65 patient population group.

There were monthly multi-disciplinary meetings with the other professionals, which included local community matrons, health visitors and social care teams. These meetings ensured there was an opportunity to discuss, monitor and review patient's needs. Clinical staff said that increasing numbers of older patients over 75 years now had a named GP and had a collaborative care plan in place. We were shown some anonymised examples of care plans. Collaborative care plans ensured that patient's needs were identified, relevant multi-disciplinary support was in place, and care was effectively coordinated.

Clinical staff demonstrated how they carried out dementia screening for patients over 60 years old, using a mini-mental-examination tool on the computer system, which in-turn provided a score for the patient. Where a potential mental health concern was triggered the patient was asked if they wanted to be referred to the memory clinic, ensuring they maintained choice and control about their care and treatment. Dementia screening checks were also offered to other population groups.

The building was wheelchair accessible and there was a hearing loop for patients who were hard of hearing or deaf.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice provided safe, effective, responsive, caring and well-led services for patients with long-term-conditions. Patients with long term conditions such as epilepsy, diabetes and hypertension were offered regular reviews of their health conditions and medication. The practice held a register of patients with long-term-conditions to ensure that people's details were routinely triggered for reviews. Patients told us that they were satisfied with the care and treatment they received and felt they were involved in decisions about their care and treatment and given choice.

The practice Quality and Outcomes scores (QOF) for long-term-conditions were adequate. For most conditions including lung diseases, cancer, dementia, hypertension and stroke, the practice scored between 97-100%. General Practice Outcome Standards (GPOS) data for May 2014 showed the practice performed within the Clinical Commissioning Group average for flu vaccinations for at risk patients. (CCG groups are clinically led groups that include all of the GPs in a geographical area. The groups are set up to deliver local healthcare). The exception to this was the practices (QOF) score for diabetes which was 85%. In particular, this had an adverse impact on patients from Black and Minority Ethnic (BAME) communities who had a high prevalence in the figures for diabetes. The practices own data showed that African patients on the practice patient-list were particularly affected by diabetes. There was more for the practice to do to ensure that scores for diabetes improved.

Patients were offered access health care services such as the community diabetic specialist nurse. We were told however, that there was a great deal of pressure on this community service, since there was only one diabetic nurse covering the local area. During the visit, we did not hear any adverse patient feedback that would indicate patients with diabetes did not receive a responsive service.

The practice described how clinical audits were used to ensure effectiveness of care and treatment for this particular population group. However, there was scope to make clinical audits more robust, to drive real improvements in patient care and safety.

The practice offered a one-stop service. For example, patients could use the phlebotomy service and have their blood pressure taken as well as foot-care. This was mainly provided by one of the GPs but also a nurse. We heard how this made it easier for patients as they didn't have to go to the local hospital.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice provided safe, effective, responsive, caring and well-led services for mothers, babies and young patients. Patients that we spoke with told us the service was responsive and they were able to obtain an appointment, when they needed it. They did sometimes experience delays if they wanted to see a specific GP. There had been an incident where a member of the reception staff had not ensured that a patient presenting at the practice and concerned about their small child was seen by a GP. Rather than ensuring that the patient was given a GP appointment, the receptionist signposted the patient directly to Accident & Emergency (A&E). The child presented with an abdominal lump, which turned out to be a hernia. The GP would have preferred to have assessed the patient before signposting to A&E. Patients said that the practice did respond in a timely way, to requests for appointments for young children and babies.

The practice was able to tell us about its patient count in terms of mothers and their expected dates of delivery over the next few months. Expectant mothers were offered antenatal care from the surgery working in collaboration with community midwives, monitoring pregnancy. Post-natal care was also provided and appointments were allocated 8 weeks after delivery alongside the baby examination. Where necessary mothers were offered a smear teas. The practice had achieved the 80% QOF target for smear tests.

Staff said the service provided appointments for teenagers who requested confidential advice on contraception and sexual health. They offered child development clinics where the lead GP offered vaccinations. Community health visitors also ran vaccination clinics, so there was some choice for mother and baby. The Quality and Outcomes Framework scores (QOF) showed that the practice had reached the target of 90% for primary and pre-school boosters.

The practice had in place care plans for patients over 18 who had multiple and complex health conditions. We saw an anonymised example of a care plan for a young person. Care arrangements were shared with members of the multi-disciplinary team to enable the young adult to remain at home for as long as possible.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice provided safe, effective, responsive, caring and well-led services for working age people (and those recently retired). Patients that we spoke with were satisfied with the appointment system at the practice. A small number of patients said they sometimes experienced delays, once they had arrived in the surgery and this had the potential to impact adversely, particularly on working age patients, who might have to get to work after their appointment.

The surgery opening hours provided working age people (and those recently retired) a degree of flexibility as opening times varied. Patients had the ability to attend appointments from 8am and GPs offered an extended hours service one evening a week. Between 12-1pm each day, GPs offered telephone consultations. However, there were no weekend surgeries offered which might better support patients who worked during week-days. There were facilities for electronic prescribing to a nominated pharmacy and patients could request repeat prescriptions on-line. On the day of the visit, we spoke with two patients who were of working age and had presented at the surgery without a pre-booked appointment and following a wait, they were seen by a GP.

NHS health checks were carried out for a total of 146 patients aged 40-74 to support the prevention, early identification and treatment of long-term-conditions.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice provided safe, effective, responsive, caring and well-led services for people in vulnerable circumstances who may have poor access to primary care. The practice said they were aware of 1 patient who was homeless and 14 patients who had been formally diagnosed as having a learning disability. The practice reported that they had carried out annual health checks for all 15 patients with a learning disability in 2013-14.

The practice provided a service for patients with drug and alcohol misuse problems. This included regular monitoring and where assessed as safe, prescribing of methadone. Patient care was jointly managed with the local substance misuse service. Patients on detox received weekly medication and their hepatitis status was monitored and hepatitis B vaccinations offered. Patients with hepatitis C were referred to the liver unit at a local hospital. The lead GP had achieved a specialist qualification in treating drug misuse problems from the Royal College of GPs (RCGP). Some 14 patients were currently being treated at the practice with another 5 attending an alternative local clinic. Patients could choose where to be treated within their local area which increased patient choice.

The practice said they had a small but increasing Vietnamese patient population and they were engaging interpreters and language-line (telephone interpretation service) facilities to ensure this population could access the service. The practice had access to language line to support access to patients for whom English was a second language. A small range of written information was translated to help communication and receptionists and GPs said they were increasingly getting to know this particular patient population to try to better understand their cultural values and health needs.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice provided safe, effective, responsive, caring and well-led services for people experiencing poor mental health. We spoke with staff from a hostel for people experiencing poor mental health. Some of these patients also had additional drug and alcohol problems.

Staff at the hostel said that residents, who were also patients of the practice, were supported by GPs to make informed decisions about their treatment and they were happy with the care the practice offered patients. Patients received effective care and treatment and their care was monitored and reviewed.

The practice had referred a number of its patients to the Increasing Access to Psychological Therapies Service (IAPT is a national initiative to improve access to psychological therapies) and the surgery had its own IAPT counsellor for one morning a week. The practice reported that all 106 patients experiencing poor mental health had received a physical health check during 2013-14.

Clinicians used a dementia screening tool /mini-mental-examination (MME) on the computer system, which in-turn provided a score for the patient. Where a potential mental health concern was triggered the patient was asked if they wanted to be referred to the memory clinic. Such checks were offered to patients including those with downs syndrome and patients over 40 years old and those with learning disabilities over 50 years. This was helping to identify patients experiencing the early signs of dementia.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users. Regulation 9 (2)**