

Figges Marsh Surgery

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Figges Marsh Surgery on 28 January 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The majority of patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand, although information about translation services was not available to patients in the waiting room.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

- The provider was aware of and complied with the requirements of the Duty of Candour.
- There was a clear leadership structure and staff felt supported by management.
- Urgent appointments were usually available on the day they were requested, but some patients said that it was difficult to get through to the practice by telephone to make an appointment.
- The practice was receiving feedback through the GP Patient Survey and Friends and Family test, but no feedback was proactively sought from patients. There was no functional patient participation group.
- Risks to patients were generally well assessed and managed.

The provider should:

- Continue to review patient feedback on appointment availability and telephone access.
- Review quality improvement activity, making more active use of the patient participation group, audit and other evidence to monitor and improve services.
- Provide information for patients on translation services in the reception and/or waiting areas.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had some clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were not always well managed. For example emergency medicines were not available for doctors to use to manage medical emergencies on home visits.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was some limited evidence of improvement as a result of local/national data and clinical audit.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisal and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

The practice is rated as good for providing caring services.

- All of the patients we spoke to, and most of the patients who completed comment cards, said they were treated with compassion, dignity and respect and felt cared for, supported and listened to.

Good



Summary of findings

- Data from the National GP Patient Survey showed patients rated the practice lower than others for some aspects of GP care, but rated nursing care highly. For example:
- 93% said the last nurse they spoke to was good at treating them with care and concern (CCG average 86%, national average 91%).
- 76% said the last GP they spoke to was good at treating them with care and concern (CCG average 81%, national average 85%).
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice hosted Livewell, a health improvement service, and ran their own clinics to support their patients with weight management and smoking cessation, because of the needs of their patient population.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments usually available the same day.
- Patient feedback from various sources (conversations during the inspection, comment cards and the GP Patient Survey) showed that some patients find it difficult to get through by telephone to make an appointment.
- 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led.

- Staff were clear about the practice values in general terms, but no clear sense of the practice ambitions for the future and their responsibilities in relation to this.

Good



Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings.
- Functional governance processes were in place, so that staff were clear about their roles and responsibilities.
- Arrangements to identify and manage risks had not ensured that all risks to patients were appropriately dealt with.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice had limited engagement with the patient participation group.
- Audit had been used to improve patient care, but fewer audits had been completed than would be expected for a teaching practice of this size.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. The practice had introduced a dedicated mobile phone number to make it easier for patients over the age of 75 to make contact with the practice.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line or above the local and national averages, for example:
 - 100% of patients aged 50 – 74 with osteoporosis and who had a fragility fracture on or after 1 April 2012 were treated with an appropriate bone-sparing agent. This was above the local average of 94% and the national average of 83%.
 - The percentage of people aged 65 or over who received a seasonal flu vaccination was lower than the CCG and national averages.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice performance for the care of people with diabetes was generally similar to the CCG and national average. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 75%, similar to the national average of 80%.
- The practice immunised fewer people on the register of diabetic patients than local and national averages. The practice immunised 67%, below the local and national averages (74% and 78%).
- Longer appointments and home visits were available when needed.

Good



Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice also identified that their patient population had high levels of obesity and diabetes mellitus. Nursing staff provided dedicated support for patients to manage their weight and stop smoking (smoking is both an independent risk factor for diabetes, and increases the likelihood that patients with diabetes will have a heart attack or stroke).

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- 74% of the practice's patients with asthma, on the register, had had an asthma review in the preceding 12 months (in line with the local average 73% and the national average of 70%).
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- 81% of women aged 25-64 had a cervical screening test recorded as performed in the preceding 5 years, comparable to the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Same day appointments were available for children and those with serious medical conditions.

Good



Working age people (including those recently retired and students)

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Good



Summary of findings

- The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered extended hours (as an enhanced service) on a Saturday morning, making it easier for patients who could not attend during normal opening hours to make appointments.
- The practice identified that some of their patients, who had recently arrived in the UK required additional support to understand the NHS health system and how to access services, particularly if they did not have English as a first language. The practice planned their appointments so that all of the doctors had ten minutes of 'administration time' after every five appointments. In practice, the doctors were able to use this time flexibly, to provide more time for patients that needed it, meaning that appointments were, on average, 12 minutes long.
- As the practice identified that many of their patients needed support to understand the preparation they needed to undertake, nursing staff developed a travel advice guide for patients that included guidance on vaccinations, disease advice and a risk assessment.

People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and those who used translation services.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- There were no policies or arrangements to allow people with no fixed address to register or be seen at the practice.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 90% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented, in the preceding 12 months, comparable to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on 7 January 2016. The results showed the practice was performing below local and national averages in some key areas. Four hundred and six survey forms were distributed and 127 were returned. This represented 2% of the practice's patient list.

- 50% found it easy to get through to this surgery by phone compared to a CCG average of 61% and a national average of 73%.
- 72% were able to get an appointment to see or speak to someone the last time they tried (CCG average 81%, national average 85%).
- 70% described the overall experience of their GP surgery as fairly good or very good (CCG average 79%, national average 85%).
- 54% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 72%, national average 78%).
- As part of our inspection we also asked for CQC comment cards to be completed by patients. We received eight comment cards. Six were wholly positive about the standard of care received. Two

patients made negative comments about getting through to the surgery by phone to make an appointment (although one patient was otherwise positive about the care they received).

We spoke with 12 patients during the inspection. All 12 patients said they were happy with the care they received and thought staff were approachable, committed and caring. Three patients said that they experienced difficulties telephoning the surgery to make an appointment, but most said that they had had no difficulties.

The practice used the NHS Friends and Family Test to collect feedback. Patients are asked if they would recommend the practice to friends and family. Between August 2015 and December 2015 33 patients responded. Fourteen patients said they were extremely likely to recommend the practice and five were likely to recommend it. One patient said that they were neither likely nor unlikely, and four said they didn't know. Four patients said that they would be unlikely to recommend the practice and five said they would be extremely unlikely. Positive comments were made about the attention and care given by doctors and nurses. Negative comments were made about getting through to the surgery by phone, appointments being too short and reception staff not being cheerful and asking too many questions.

Figges Marsh Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist adviser, a second CQC inspector and a practice nurse specialist adviser.

Background to Figges Marsh Surgery

The practice is based in Mitcham, a suburban area. The surgery is on a busy road. There is no dedicated car park, but on street parking is available around the surgery and there is a pay-and-display car park close by. The area is well-served by local buses.

Figges Marsh Surgery is registered with the CQC for treatment of disease, disorder or injury; maternity and midwifery services and diagnostic and screening procedures. The practice has a contract with the NHS to provide Personal Medical Services (PMS). It has also signed up to provide enhanced services (extra services that aren't required by the standard GP contract). The practice's enhanced services are: flu and pneumococcal immunisations, remote care monitoring, and extended opening hours.

There are four GPs based at the practice, three partners (all male) and one salaried GP (who is female). GP working time is generally arranged into sessions. A session is 4 hours and so the working week is divided into 10 sessions. Each of the partners at Figges Marsh Surgery work eight sessions per week and the salaried GP works four sessions per week.

Figges Marsh Surgery has three practice nurses and a health care assistant. They provide 100 hours a week of nursing care. All of the nursing staff are female. The practice has been accredited to teach doctors training to become GPs after having completed medical school.

The practice is open between 8.00am and 6.30pm Monday to Friday. Appointments are available from 8.00am to 11.30am and 13.30pm to 17.40pm. The surgery also offers appointments on Saturday from 8.30am to 11.30am. Outside of surgery hours, patients are advised to visit the local NHS walk-in centre or to contact the locally agreed out of hours provider.

At the time of the visit, 7112 patients were registered with the practice. Life expectancy of the area is in line with the average for England, and there are lower numbers of people with long-standing health conditions and those claiming disability benefits and unemployed people than the averages for England.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 January 2016.

During our visit we:

- Spoke with a range of staff including GPs, practice nurses, health care assistant, reception and administration staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?

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

We also looked at how well services were provided for specific groups of people and what good care looked 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).

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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out adequate analysis of the significant events.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, after a patient was wrongly administered an injection, the staff member was given extra training and the error was discussed in a meeting of doctors and nurses. Eight incidents were recorded in the twelve months prior to the inspection. All had been reviewed and shared with relevant staff.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, however some improvements were required:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- Two of the practice partners acted as leads for safeguarding, one for adult and child safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies.

- Staff we spoke with demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3. Nursing staff were trained to level 2.
- We saw evidence that safeguarding referrals were being made, and managed as significant events to ensure staff remained vigilant to possible safeguarding concerns.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security).
- The practice compared their prescribing to that of other practices, using information provided by the CCG and data from ePACT.net. (ePACT.net is a system which allows authorised users to see and compare prescription data).
- An audit of antibiotic prescribing was carried out in February 2012, which was repeated in December 2014. This showed some areas of improvement and some areas of deterioration against the CCG management of infection guidance for primary care. The practice showed us evidence that they were performing above local practices for antibiotic prescribing.
- The practice met monthly with local pharmacists to discuss and resolve prescribing issues.
- Prescription pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in

Are services safe?

line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). The practice also had a system of Patient Specific Directions (PSDs) to enable Health Care Assistants to administer vaccinations (after specific training when a doctor or nurse were on the premises). (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis). However the system was not in line with legislation which requires an individually signed instruction for each patient (giving full details of the medicine to be administered). The system in place was a list of patients with a cover sheet signed by a doctor. We raised this during the inspection, and the following day the practice sent us details of a new system of signed-off individual instructions in the electronic patient records.

- Changes requiring recruitment checks for staff in GP practices came into effect in 2013. We reviewed eight personnel files to assess whether appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). We reviewed seven staff files. All members of staff employed after 2013 had had appropriate checks.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Some risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessment (carried out by an external company on 5 December 2015) and carried out regular fire drills. All

electrical equipment was safety checked on 27 January 2015 and clinical equipment was checked to ensure it was working properly on 17 August 2015. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. The practice had had its water system tested for legionella on 26 January 2016, and were awaiting the result of the tests. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to respond to emergencies and major incidents in the surgery.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in a secure area behind the reception desk. All staff knew the location of emergency medicines.
- The practice did not have all of the emergency medicines that we would expect and had not completed a risk assessment to make the decision not to hold certain emergency medicines. We were told that GPs took medicines from the practice supply to manage medical emergencies in a patients home. The day after the inspection the practice sent us evidence that emergency medicines had been ordered to create a supply for GPs to take on home visits.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that some of the guidelines were followed (on particular types of medicine) through audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

The most recent published results were 90% of the total number of points available, with 7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice exception reporting was in line with the CCG and national averages of 8% and 9.2%.

This practice was in line with local/national averages for most clinical targets in 2014/15.

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 79%. This is similar to the CCG and national average of 81%
- Performance for mental health related indicators was similar to or slightly higher than the CCG and national averages. For example, the percentage of patients diagnosed with dementia whose care was reviewed in a face-to-face review in the preceding 12 months was 90% compared to the national average of 84%.

- QOF performance for most diabetes related indicators was generally similar to the CCG and national average. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 75%, similar to the national average of 80%.

However, the practice was an outlier for:

- The percentage of people on the register of diabetic patients who received a flu immunisation. The practice immunised 67%, below the local and national averages (of 74% and 78%).
- 63% of people aged 65 or over received a seasonal flu vaccination, which was lower than the national average of 73%.

Flu vaccination rates for at risk groups (45%) was comparable to the national average.

Staff at the practice told us that they gave fewer flu immunisations than other practices as many of their patients spent winter abroad, and therefore did not take up the offer of a flu immunisation. No audit or other analysis had been carried out to confirm this hypothesis.

The practice made some use of clinical audits for quality improvement.

- Doctors had carried out two completed audits and one qualitative study in the last three years. A completed audit cycle includes an initial audit; change implemented and re-audit to demonstrate improvement. The results and action plans from all of the studies were discussed in clinical meetings.
- Findings were used by the practice to improve some aspects of patient care. For example, as a result of an audit of an unlicensed use of a particular medicine, five patients had their medicines reviewed, three patients were transferred to a different medicine and the other two patients were kept under review. An audit of antibiotic prescribing (carried out in January 2012 and repeated in December 2014) showed that some aspects of the practice prescribing of antibiotics had worsened against the local standards. The practice developed an action plan, which included putting a copy of the local antibiotic prescribing guidelines in all clinical rooms and repeating the audit in December 2015. The audit had not been repeated when we visited (in January

Are services effective?

(for example, treatment is effective)

2016), but the practice had used locally published data to benchmark their performance. This showed that (in May 2015) the practice was meeting the local targets for antibiotic prescribing.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and a range of in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those with chronic conditions (e.g. diabetes mellitus). Patients were then signposted to the relevant service.
- The practice hosted LiveWell, a free health improvement service available to anyone over the age of 18 who lives or works in the London Borough of Merton. The service supported patients with being more physically active,

Are services effective?

(for example, treatment is effective)

eating well and improving diet, reducing alcohol intake and weight management. Information about Livewell and the practice's own services were available in reception.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by offering opportunistic testing for patients attending the practice for other reasons, and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were variable, with some rates higher and other lower than the CCG averages. The immunisation rate for most

vaccinations given at 12 months was comparable with the CCG average. The percentage of children receiving the hepatitis B vaccination was significantly above the CCG average (100%, compared to the CCG average of 13%).

Immunisation rates for the vaccinations given at two years old ranged from 64% (Dtap/IPV/Hib, below the CCG average of 89%) to 100% (Hep B, the same as the CCG average). Rates for the vaccinations given at five years old ranged from 51% (Dtap/IPV Booster, lower than the CCG average of 66%) to 81% (Pertussis Primary and Infant Hib, lower than the CCG average of 90% for these vaccinations).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and they had the facility to offer them a private room to discuss their needs.

Of the eight patient Care Quality Commission comment cards we received, seven were positive about the service experienced. Patients said that staff responded compassionately when they needed help and provided support when required. One patient commented on their card that doctors didn't always give the patient a full ten minute appointment or provide what the patient wanted. The practice appointments were, on average, twelve minutes long.

Patients we spoke with said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the surgery's patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

One hundred and twenty seven Figges Marsh Surgery patients responded to the national GP patient survey. Patients said that they felt treated with compassion, dignity and respect by nursing staff, but not consistently by GPs. The practice was above average for its satisfaction scores on consultations with nurses, but satisfaction scores for consultations with GPs were below average. For example:

- 93% said the last nurse they spoke to was good at treating them with care and concern (CCG average 86%, national average 91%).

- 79% said the GP was good at listening to them compared to the CCG average of 85% and national average of 89%.
- 73% said the GP gave them enough time (CCG average 82%, national average 87%).
- 88% said they had confidence and trust in the last GP they saw (CCG average 94%, national average 95%)
- 76% said the last GP they spoke to was good at treating them with care and concern (CCG average 81%, national average 85%). 82% said they found the receptionists at the practice helpful. This is comparable to the CCG average of 85% and the national average of 87%).

Care planning and involvement in decisions about care and treatment

All of the 12 patients we spoke with told us 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 available to them, although two patients said that it would be good to have longer explanations of the possible side effects of their medications.

Patient feedback on the comment cards we received was also largely positive and aligned with these views.

Results from the national GP patient survey showed patients were generally positive about how GPs involved them in planning and making decisions about their care and treatment. Results were slightly below local averages. For example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 71% said the last GP they saw was good at involving them in decisions about their care (CCG average 78%, national average 82%).

Patients were very positive in the GP patient survey about how nurses involved them in planning and making decisions about their care and treatment, with the results for the practice above local and national averages. For example:

Are services caring?

- 96% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG average: 86%, national average:90%)
- 92% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care (CCG average:80%, national average:85%).

Practice staff spoke a number of languages (including Arabic, Punjabi and Urdu) and told us that this helped them to support patients who did not have English as a first language. Staff also told us that professional translation services were available for patients who did not have English as a first language. We did not see any notices in the reception areas to inform patients these services were available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room 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. The practice had identified 1% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and often visited the family at home to provide support and to provide details of support services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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.

- The practice offered extended hours (as an enhanced service) on a Saturday morning, making it easier for patients who could not attend during weekday opening hours to make appointments.
- There were longer appointments available for vulnerable patients including those with a learning disability or who needed translation services.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled facilities, a hearing loop and translation services available. All consulting and treatment rooms were fully accessible, as they are on the ground floor, with wide doorways to allow wheelchair access.
- The practice offered phlebotomy (as an enhanced service), meaning that patients did not have to travel to a hospital to have blood taken for testing.
- When we visited, the practice was about to begin hosting a physiotherapy service, to make it easier for their patients to access this support.
- The practice identified that some of their patients, who had recently arrived in the UK required additional support to understand the NHS health system and how to access services, particularly if they did not have English as a first language. The practice planned their appointments so that all of the doctors had ten minutes of 'administration time' after every five appointments. In practice, the doctors were able to use this time flexibly, to provide more time for patients that needed it, meaning that appointments were, on average, 12 minutes long.
- The practice also identified that their patient population had high levels of obesity and diabetes mellitus (compared to local and national averages). Nursing staff provided dedicated support for patients to manage

their weight and stop smoking (smoking is both an independent risk factor for diabetes, and increases the likelihood that patients with diabetes will have a heart attack or stroke).

- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. As the practice identified that many of their patients needed support to understand the preparation they needed to undertake, nursing staff developed a travel advice guide for patients that included guidance on vaccinations, disease advice and a risk assessment.
- The practice introduced a special telephone line (a mobile number) for patients over 75, to make it easier for this group to get through on the telephone.

Access to the service

The practice was open between 8.00am - 6.30pm Monday to Friday. Most appointments were available only 'on the day', either by telephone or by attending the surgery in person, from 8am.

Appointments were from 8.00am to 11.30am every morning and 13.30pm to 17.40pm daily. Telephone consultation slots were available 15.00pm- 15.30pm daily. Extended surgery hours were offered from 8.30pm to 11.30pm every Saturday.

In addition to 'on the day' consultations, appointments could be booked up to six weeks in advance.

Results from the national GP patient survey showed that patient satisfaction with access to care and treatment was mixed. Some satisfaction scores were comparable to local and national averages, for example:

- 71% of patients were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 75%.
- 46% patients said they always or almost always see or speak to the GP they prefer (CCG average 49%, national average 59%).

However, patient satisfaction with two aspects was lower than the local and national averages:

- Only 50% patients said they could get through easily to the surgery by phone (CCG average 61%, national average 73%).

Are services responsive to people's needs?

(for example, to feedback?)

- And 72% were able to get an appointment to see or speak to someone the last time they tried (CCG average 81%, national average 85%).

Patients we spoke to told us on the day of the inspection that they were able to get appointments when they needed them, but three people told us that it could be difficult to get through on the telephone.

The practice had recently (in the last five months) engaged a third receptionist and upgraded the telephone system, so that three members of staff could answer additional phone calls (two from the main reception desk) and one from a back desk. Practice staff told us that this had made it easier for patients to get through to the surgery.

The practice operated a cancellation list so that patients unable to book a same day appointment could be slotted in if another patient cancelled.

Not all of the patients we spoke to were aware of the option to have a telephone consultation. This service was advertised on the practice website but not in reception.

To meet its NHS contract, the practice was required to provide an average of 490 appointments per week. The practice told us that it provided 583 on average per week in 2014 – 2015.

The practice had a high numbers of patients who made appointments but did not attend (Did Not Attend or DNA rate). To try to improve this, the practice had introduced an SMS reminder service, moved more appointments to 'on the day' and offered telephone consultations. Some patients who repeatedly failed to attend were offered only same day appointments. At the time of our visit, there were still on average more than 200 appointments a month 'lost' in this way.

Practice staff told us that Figges Marsh Surgery has a high turnover of patients, with 900+ patients (more than 10% of the practice list) leaving the practice list every year. The list remained roughly the same due to new patients joining.

We discussed with the practice what action they had taken to look into the high DNA rates and patient turnover. Staff confirmed that no audit had been undertaken into these, to investigate whether improvement could be made, although they had identified some patients' who were only given on the day appointments to reduce the risk of non-attendance.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Leaflets were available in the reception area to help patients understand the complaints system.

We looked at seven complaints received in the last 12 months and found that these were dealt with in a timely way, with openness and transparency. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, two complaints about reception staff attitudes led to staff receiving customer service training.

Are services well-led?

Good 

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

Our findings

Vision and strategy

- Staff had a general sense of the practice values for example providing safe patient care. The practice did not have a mission statement. The Statement of Purpose (required by legislation) was displayed on the practice website.
- The practice did not have a formal written strategy or business plan.

Governance arrangements

Functional governance arrangements were in place to support the delivery of the strategy and good quality care:

- There was a clear staffing structure and staff we spoke to were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.

Audit had been used to improve patient care, but fewer audits had been completed than would be expected for a teaching practice of this size. No work had been undertaken to investigate the lower than expected uptake figures for flu immunisations for over 65s and diabetic patients.

The arrangements for identifying, recording and managing risks and issues, and implementing mitigating actions were generally robust.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice; they had the opportunity to raise any issues at team meetings; they felt confident in doing so and felt supported if they did. We noted that practice meetings for the whole staff team were held every six months.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. They gave examples including that the partners provided take away food for evening meetings and supportive handling of personal issues.

Seeking and acting on feedback from patients, the public and staff

- The practice gathered feedback from staff through monthly staff meetings, staff appraisal and twice-yearly practice-wide meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- All GP practices in England are required to have a patient participation group (PPG). There is no set model for the PPG, but they should meet on a regular basis, with members of the practice team, to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice. Active PPGs will often run surveys to find out other patients' views, and will communicate with the wider patient body.
- We met with members of the Figges Marsh Surgery practice patient participation group. They explained to us that they were a social group and did not consider themselves part of the practice processes. The group met monthly, with no involvement from the practice, for conversation and table games. These meetings were informal, and so were not minuted. Staff from the practice met with the group annually. These meetings were minuted. Members of the group that we met did not recall the last meeting or being involved in any quality improvement activity.

Are services well-led?

Good 

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

- The practice was using the Friends and Family Test (FFT) and GP Patient Survey. Patients responded to the FFT between August 2015 and December 2015, and 127 to the most recent GP Patient Survey. This represents feedback from just over 2% of the practice's patients.

Continuous improvement

There was a strong focus on education and training within the practice.

The practice was a training practice for GPs, and also took medical students. When it had difficulty recruiting a practice nurse, the practice recruited a nurse with a community nursing background and trained her as a practice nurse.

Training was used to improve areas of identified underperformance, for example, customer service training was provided to reception staff following patient complaints. The practice had a meeting every Tuesday for doctors and nurses, either for practice clinical discussion or meetings with other professionals. Before these meetings, the practice arranged external experts to come to improve staff knowledge of particular subjects, for example a consultant specialist in the management of diabetes and the GP liaison manager from the local eye hospital.

The practice had an action plan, but it covered only limited aspects of the practice's performance and it was not clear how the areas to target had been identified as priorities. No evidence was gathered that allowed the practice to assess the impact of the changes made.