Dr Patrick Morant

Quality Report

Sydenham Surgery, 2 Sydenham Road, Sydenham,
London, SE26 5QW
Tel: 0208 7788552
Website: www.sydenham.gpsurgery.net

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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 Patrick Morant also known as Sydenham surgery is a small practice providing general medical services to approximately 4000 people in the local area. The practice provides a range of services including new patient health checks, travel health advice and immunisations. Health screening services include cervical smears, blood pressure checks, a diabetes clinic, asthma and COPD reviews. The practice also provides smoking cessation, diet and contraceptive advice.

During our inspection on 7 July 2014, we spoke with two male GPs, a female GP, a nurse, five non-clinical staff and eight patients. We could not review comment cards where patients shared their views and experiences of the service because although they were put on display prior to our inspection patients had chosen not to complete them. Patients we spoke with said they were generally happy with the service provided. Patients said the GPs were good and understood them. They were complimentary about the reception staff and said the staff were professional and treated them with respect.

We found the practice was overall safe, effective, caring and responsive but we did identify some areas which required improvement. The practice was clean with procedures in place to minimise the risks of cross infection. Serious incidents were managed appropriately and learning shared with staff. Medicines were managed safely and staff were trained to deal with medical emergencies. Safeguarding procedures were in place and staff had received training in safeguarding children. However we found that non-clinical staff had a limited knowledge of recognising the signs of abuse in adults and they had not completed any formal training in safeguarding vulnerable adults.

The practice had procedures in place to ensure care and treatment was delivered in line with current legislation and guidance. The practice measured its effectiveness through clinical audit, their Quality and Outcomes Framework (QOF) performance and peer review and worked with other services to deliver effective care to patients with complex needs. Patients were treated with respect and their consent was sought before examinations and medical procedures were carried out. However, staff acting as chaperones had not received training.

The practice had services to meet the needs of the different population groups it served. For example clinics for patients with long term conditions and sexual health services. The practice had an accessible appointments system including same day and pre-bookable appointments, extended surgery hours, telephone consultations and home visits. Complaints were investigated and dealt with appropriately, but information about the complaints process was not readily available and patients had to ask for information about how to complain.

The practice was not well-led. Some systems were in place to monitor the quality of services provided but mechanisms to obtain patient feedback were limited. The practice did not have a Patient Participation Group (PPG) and was not carrying out regular patient surveys. There was no suggestion box for patients to leave comments on the service and the practice had not responded to negative comments on the NHS Choices website.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Many aspects of the service were safe but some aspects required improvement. Procedures were in place to ensure serious incidents and accidents were reported and learning from incidents and accidents was shared with staff to improve the service. Safety alerts received from the NHS and healthcare agencies were dealt with appropriately. Medicines were managed safely and staff had received training to deal with medical emergencies.

Systems were in place to monitor risk including risk assessments for health and safety and audits for infection prevention and control. Safeguarding procedures were in place to protect children from harm. However non-clinical staff did not have sufficient knowledge of safeguarding vulnerable adults and they had not completed safeguarding vulnerable adults training.

Appropriate pre-employment checks had been carried out on staff before they started working for the practice.

Are services effective?

The service provided was effective. Best practice guidance was used to inform patient care and treatment and staff were aware of relevant legislation for obtaining consent from patients.

The practice had completed a range of clinical audits and participated in peer review to evaluate and improve outcomes for patients. It engaged with other organisations and healthcare professionals to provide care and treatment for patients with complex needs.

Staff had appraisals and received appropriate training for their role.

The practice provided clinics for patients with long term conditions and health promotion services. Staff were suitably qualified and trained to deliver effective care to patients.

Are services caring?

The service provided was caring however some improvements were required. Feedback we received from patients during our inspection was positive. Patients were complimentary about the reception staff and were happy with the GPs and nurses. However 17 patients left negative comments on NHS Choices website over a four year period and feedback from the National Patients Survey 2013 was not positive.

Summary of findings

Consent was sought from patients before carrying out examinations and medical procedures. We found that the practice did not provide support to patients during periods of bereavement and staff who acted as chaperones had not received any formal training.

Are services responsive to people's needs?

The service was responsive to patients however some improvements were required. The practice planned its services to meet the needs of the local population group it served. For example to meet patients' needs the practice offered health screening services, smoking cessation and dietary advice.

A range of appointment times were available and patients could book an appointment in person or over the phone. Patients said they were confident they would be seen appropriately in an emergency and could get an appointment that suited their needs. Telephone advice was available and home visits for patients who were housebound.

Complaints had been dealt with appropriately however the complaints procedure was only available on request. There was an interpreter service and a sign language service to help patients with their communication needs. However not all reception staff were aware of how to access the sign language service.

Are services well-led?

The service was not well-led.

The practice had some systems in place to monitor the quality of service provided. However we found that the practice did not have an active Patient Participation Group (PPG) to represent patients and feedback their views of the practice. We also found the practice had not completed an internal patient survey since before 2011, there was no suggestion box for patients to comment on the service and there was no opportunity for patients to leave their comments on the practice website.

There were leadership and governance arrangements in place. Staff were aware of their roles and responsibilities and who to report to if they had any issues.

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 services for older people including an enhanced service to reduce unnecessary emergency admissions to secondary care, annual reviews for patients with dementia and regular meetings with the palliative care team to provide appropriate end of life care.

People with long-term conditions
The practice provided services to patients with long term conditions including reviews of patients managing diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Elderly patients with long term conditions had been reviewed to reduce the likelihood of hospital admission.

Mothers, babies, children and young people
The practice provided services for mothers, babies, children and young people. Services included child immunisations, contraceptive clinics, antenatal and postnatal checks. The practice had recently started offering implants and intra-uterine contraceptive devices to patients which was proving popular.

The working-age population and those recently retired
The practice provided services for working age people including health screening services and an extended hours clinic every Monday. Appointments could be booked in advance to fit around patients' working day and telephone consultations available daily.

People in vulnerable circumstances who may have poor access to primary care
The practice provided services to people in vulnerable circumstances including access to the practice for patients who were homeless or had a temporary address and regular health checks for patients with learning disabilities to improve outcomes for them.

People experiencing poor mental health
The practice supported patients experiencing poor mental health including annual health checks by the practice nurse. The practice worked with community health workers to improve outcomes for patients and made best interest decisions for patients who lacked capacity when necessary.

Summary of findings

What people who use the service say

We spoke with eight patients during the course of our inspection. We could not review comment cards where patients and members of the public shared their views and experiences of the service because none had been completed prior to our inspection. All the patients we spoke with said they were generally happy with the service provided. They said the GPs were good and understood them. Patients were also complimentary about the reception staff and said they were professional and treated them with respect.

Areas for improvement

Action the service MUST take to improve

The practice did not have systems in place to seek the views of or engage with patients. For example they did not carry out surveys or have a suggestion box.

No Patient Participation Group (PPG) to represent patients and feedback their views of the practice to staff.

Action the service SHOULD take to improve

Training in safeguarding vulnerable adults.

Training in how to chaperone patients.

Training in how to support bereaved patients.

Improve staff awareness of how to access the British Sign Language service.

Implement an online system for booking appointments.

Display information about the complaints procedure.

Dr Patrick Morant

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. It included a GP, a practice manager and an expert-by-experience. They were all granted the same authority to enter Sydenham surgery as the CQC inspector.

Background to Dr Patrick Morant

Sydenham surgery is located in the London borough of Lewisham. The surgery is a small practice providing primary medical services to approximately 4000 patients in the local community. The medical practice is part of the NHS Lewisham Clinical Commissioning Group (CCG) which is made up of 44 GP surgeries. The staff comprises of one male GP partner, one female GP partner, a long term male locum GP, two nurses, a practice manager and a small team of non-clinical staff.

The practice provides a range of services including new patient health checks, travel health advice and immunisations. Health screening services include cervical smears, blood pressure checks, a diabetes clinic, asthma and COPD reviews. The practice also provides smoking cessation, diet and contraceptive advice. Its opening hours are 9.00am to 11.00am and 4.00pm to 6.30pm Monday to Friday with extended hours to 7.30pm on Mondays.

The age range of patients is predominantly 15-44 years. The London borough of Lewisham has a growing population and higher than average proportion of black and minority ethnic residents. The levels of deprivation and life expectancy for both males and females in Lewisham are higher than the England average with early deaths due to heart disease, stroke and cancer.

Why we carried out this inspection

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

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

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
- People experiencing poor mental health.

Detailed findings

Prior to our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, NHS England and NHS Lewisham Clinical Commissioning Group (CCG) to share what they knew about the service. We carried out an announced visit on 07 July 2014. During our visit we spoke with a range of staff including three GPs, a practice nurse, the practice manager and four non-clinical staff. We spoke with eight patients who used the service. We could not review comment cards where patients and members of the public shared their views and experiences of the service because although they were put on display in the reception area patients had chosen not to complete them.

Are services safe?

Our findings

Many aspects of the service were safe but some aspects required improvement. Procedures were in place to ensure serious incidents and accidents were reported and learning from incidents and accidents was shared with staff to improve the service. Safety alerts received from the NHS and healthcare agencies were dealt with appropriately. Medicines were managed safely and staff had received training to deal with medical emergencies.

Systems were in place to monitor risk including risk assessments for health and safety and audits for infection prevention and control. Systems were in place to monitor risk including risk assessments for health and safety and audits for infection prevention and control. Safeguarding procedures were in place to protect children from harm. However not all staff had sufficient knowledge of safeguarding vulnerable adults and they had not completed safeguarding vulnerable adults training.

Appropriate pre-employment checks had been carried out on staff before they started working for the practice.

Safe patient care

The practice had policies and procedures in place for reporting serious incidents and accidents. Staff were aware of the action to take following a serious incident or accident. The practice had a protocol in place to ensure safety alerts received from the NHS and the Medicines and Healthcare products Regulatory Agency (MHRA) distributed to staff and acted on. Safety alerts were discussed in staff meetings to ensure all staff were aware and the meeting minutes we reviewed confirmed this.

Learning from incidents

The practice had a significant event policy in place and it was followed by staff. Incidents and accidents were discussed in clinical meetings to ensure learning was shared with all appropriate staff and this was confirmed by the meeting minutes we reviewed. We saw examples of three incidents and accidents that had occurred in the previous six months. The details of each incident or accident had been logged, analysed and an action plan formulated to reduce the likelihood of reoccurrence.

Safeguarding

A child protection policy was in place including a designated GP who ensured any concerns were reported to the local child protection team. GPs and nurses had completed training in child protection to Level three and non-clinical staff to Level one. Both clinical and non-clinical staff were able to describe the procedure for reporting any concerns and were aware of their level of responsibility. GPs attended child protection meetings to share knowledge and best practice.

Safeguarding cases were also discussed in staff meetings which included vulnerable adults. However two non-clinical staff we spoke with were not aware of how to recognise different types of abuse in adults. We also found that non-clinical staff had not received training in safeguarding vulnerable adults and there was no safeguarding vulnerable adults policy in place. The practice manager acknowledged that this was an area for improvement and said training would be made available to all staff to improve their knowledge.

Monitoring safety and responding to risk

Processes were in place to monitor safety and respond to risk. For example health and safety risk assessments for fire and building security had been carried out. Risk assessments were reviewed regularly and control measures put in place where necessary. Provisions were in place to cover staff shortages. The practice used a locum agency to provide cover for GPs during periods of illness or annual leave and there was a sufficient number of nurses and reception staff to cover each other when staff were absent.

Medicines management

There was a designated nurse who was responsible for medicine management. Emergency medicines were stored safely in the nurses room including anaphylaxis (acute allergic reaction) emergency kits. Records confirmed that medicines were checked on a regular basis by the designated nurse to ensure they were in date and fit for purpose. Immunisations and vaccines were stored in fridges and were checked daily to ensure they were stored within the correct temperature range. A first aid kit was available for minor injuries. There were no controlled drugs stored at the practice.

Cleanliness and infection control

The practice had an infection control policy and in place and staff followed NHS infection control guidelines. The practice had recently completed an infection control audit which had highlighted areas for improvement and actions

Are services safe?

with timescales for implementation agreed. Staff had completed training in infection control and there was a designated staff member responsible for ensuring infection control procedures were followed.

The nurses room and consultation rooms were clean and well equipped with hand wash facilities including soap, paper towels and hand gels and personal protective equipment. A cleaning rota was displayed and the practice was cleaned daily by a professional cleaning company. Waste was segregated and disposed of appropriately. Clinical staff had been vaccinated against Hepatitis B and a sharps injury protocol was displayed as a quick reference for staff.

Staffing and recruitment

The practice had sufficient staff to meet patients' needs. We reviewed six staff files including four clinical staff and two non-clinical staff. We found that all the necessary pre-employment checks had been carried out on staff including the long term locum. These checks included Disclosure and Barring Service (DBS) checks and references from previous employment. We saw evidence that staff had completed an induction program when they started working for the practice.

Dealing with Emergencies

Staff had been trained to deal with medical emergencies. This included training in basic life support and cardiopulmonary resuscitation (CPR) for all staff and in addition training in anaphylaxis (acute allergic reaction) management for clinical staff. The training had been completed on an annual basis and the training records we viewed confirmed this. Staff had completed training in fire safety and fire evacuation protocols were displayed for staff and patients to reference in the event of a fire. Fire drills had been regularly practiced to ensure patients and staff could be evacuated safely in the event of a fire.

Equipment

The consultation rooms were equipped with appropriate medical equipment such as spirometers and peak flow meters to test for lung conditions. We saw records that demonstrated that equipment had been calibrated within the last 12 months. Fire safety equipment was fit for purpose and we saw evidence of monthly fire equipment checks including fire alarms and fire extinguishers. Portable appliance testing (PAT) of electrical equipment had also been carried out in the last 12 months.

Are services effective?

(for example, treatment is effective)

Our findings

The service provided was effective. Best practice guidance was used to inform patient care and treatment and staff were aware of relevant legislation for obtaining consent from patients.

The practice had completed a range of clinical audits and participated in peer review to evaluate and improve outcomes for patients. It engaged with other organisations and healthcare professionals to provide care and treatment for patients with complex needs.

Staff had appraisals and received appropriate training for their role.

The practice provided clinics for patients with long term conditions and health promotion services. Staff were suitably qualified and trained to deliver effective care to patients.

Promoting best practice

The practice used best practice standards and guidance, including guidelines set by the National Institute for Health and Care Excellence (NICE) and the Royal College of General Practitioners (RCGP) to inform care and treatment. For example GPs used the NICE guidelines to treat cardiovascular disease and asthma. GPs attended annual GP update courses to ensure they were up to date with national guidelines. GPs were aware of current legislation including the Mental Capacity Act 2005, the Children Act 2006 and Gillick competencies. For example GPs made best interest decisions for patients who lacked capacity in accordance with the Mental Capacity Act 2005. We saw evidence that staff shared best practice at clinical meetings. Meetings were minuted to ensure staff who could not attend were updated.

Management, monitoring and improving outcomes for people

GPs had carried out a range of clinical audits to evaluate and improve outcomes for patients. For example an audit of osteoporotic fractures had been completed. As a result of the audit patients identified with osteoporotic fractures had been put on a bone protection plan with the aim of improving outcomes for them. We also saw evidence of completed audits for prescribing of medicines to ensure improved outcomes for patients. For example the practice had completed an audit of a medicine to prevent the formation of blood clots to ensure patients were being prescribed it appropriately. The results of the audit had been analysed and patients requiring a medication review identified.

Audits had been discussed in clinical meetings and best practice shared. The practice had scored positively in Quality and Outcomes Framework (QOF) points in the previous year. The QOF is a national group of indicators, against which practices score points according to their level of achievement in four domain areas including clinical, organisational, patient experience and additional services. Areas where the practices' clinical performance could be improved had been identified and action taken. For example based on QOF performance the practice had reviewed all patients with heart failure with the aim of improving outcomes for them. Procedures were in place to ensure patients were referred appropriately to specialist care and received their appointments promptly.

Staffing

We reviewed six staff files which included three GPs, a nurse and two non-clinical staff. They demonstrated that staff had the appropriate qualifications and training to meet patients' needs. There was evidence that GPs were registered with the General Medical Council (GMC) and the nurse registered with the Nursing and Midwifery Council (NMC). Staff had completed training in various topics including basic life support, safeguarding children, infection control, fire safety and information governance. Nurses had completed training specific to their job role including courses in immunisations and vaccinations and smoking cessation advice. An induction programme was in place for new staff which included a detailed introduction to the job and the practices' policies and procedures.

GPs had completed their annual appraisals and they were working towards meeting the GMC requirements for revalidation. The practice manager had carried out annual appraisals for non-clinical staff to assess performance and identify any development needs.

Working with other services

The practice had developed close working relationships with other organisations and healthcare professionals. For example GPs attended quarterly multi-disciplinary team meetings involving the district nurse, health visitor, community matron, palliative care nurse and a diabetic nurse to plan care and treatment for patients with complex needs and patients with poor mental health. GPs attended

Are services effective?

(for example, treatment is effective)

locality group meetings with other practices on a monthly basis to review care, share best practice and compare outcomes for patients. Topics reviewed included referrals to specialists and secondary care and unplanned admissions to hospital and measles, mumps and rubella (MMR) vaccination data. The practice also liaised with Macmillan nurses to plan end of life care for patients. GPs shared information with the out of hours service to ensure patients' clinical notes were accurate and their needs met. The senior GP also attended regular meetings with the local Clinical Commissioning Group (CCG).

Health, promotion and prevention

The practice provided a variety of information on health promotion to help patients make informed decisions about their health and wellbeing. Health promotion was carried out by both the practice nurses and the GPs. Nurses offered smoking cessation advice and directed patients to alcohol awareness services when appropriate. The nurses offered sexual health services including health screening for sexually transmitted diseases. A dietician attended the practice once per month to consult patients and advise them on a healthy diet. All new patients registered with the practice received a health check by a nurse and were referred to the GPs if necessary. The practice routinely sent out letters to patients over 40 years old to invite them for a health check where health promotion advice was given. The practice nurses ran diabetes and asthma clinics to improve the health of patients managing these conditions.

Are services caring?

Our findings

The service provided was caring however some improvements were required. Feedback we received from patients during our inspection was positive. Patients were complimentary about the reception staff and were satisfied with the GPs and nurses. However 17 patients left negative comments on NHS Choices website over a four year period and feedback from the National Patients Survey 2013 highlighted some areas for improvement. For example the practice scored below the CCG average in terms of GPs listening to patients needs, explaining tests and treatments to them and patients recommending the service to others.

Consent was sought from patients before carrying out examinations and medical procedures. However we found that the practice did not provide support to patients during periods of bereavement and staff who acted as chaperones had not received any formal training.

Respect, dignity, compassion and empathy

We observed staff talking with patients in a calm and polite manner. The receptionists knew patients well and treated them with respect. All the patients we spoke with said they were satisfied with the GPs. One in particular who had experienced poor mental health said the GPs and other staff were excellent at dealing with her issues and those of her son, who was autistic. Patients' medical records were stored confidentially behind the reception desk which was accessible to staff members only and consultations were carried out with the consultation room door closed so conversations could not be overheard.

The practice had a chaperone policy in place and the details of how to access the service displayed. This allowed for patients to have a third party present during a consultation, examination or medical procedure if they so wished. We were told that staff acted as chaperones whenever a patient requested one. However, we found no evidence that the practice had provided any formal training to staff to carry out this role appropriately. We also found that the practice did not offer support to patients during times of bereavement. One patient who went through bereavement recently had been surprised that she heard nothing from the practice after her husband passed away. Staff confirmed that the practice did not offer support through periods of bereavement.

Involvement in decisions and consent

The practice had procedures in place to gain consent. We saw evidence that informed consent was sought for implants and intra-uterine contraceptive devices. Patients had a choice of either a male or female GP when booking appointments. Patients said that the GPs explained their health conditions and different types of treatment available however the National Patient Survey 2013 showed that the practice scored below the CCG average in terms of listening to patients and explaining tests and treatments to them. Patients felt involved in decisions relating to their care and treatment and staff treated them with dignity and respect. The practice worked with carers and relatives to make best interest decisions for patients who lacked capacity in accordance with the Mental Capacity Act 2005.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was responsive to patients however some improvements were required. The practice planned its services to meet the needs of the local population group it served. For example to meet patients' needs the practice offered health screening services, smoking cessation and dietary advice.

A range of appointment times were available and patients could book an appointment in person or over the phone. Patients said they were confident they would be seen appropriately in an emergency and could get an appointment that suited their needs. Telephone advice was available and home visits for patients who were housebound.

Complaints had been dealt with appropriately however the complaints procedure was only available on request. There was an interpreter service and a sign language service to help patients with their communication needs. However not all reception staff were aware of how to access the sign language service.

Responding to and meeting people's needs

There was evidence that the practice planned services to meet the needs of the population group it served. For example there was a higher than average prevalence of patients with heart disease, lung cancer and obesity in the local population group. To meet this need the practice provided regular blood pressure checks, smoking cessation and dietary advice for patients.

There was a high prevalence of sexually transmitted diseases (STD) in the local population and the practice provided services to meet the needs of these patients. For example contraceptive advice, health screening for STD and HIV tests. The practice also provided regular reviews for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) and patients with poor mental health.

The practice did not have a Patient Participation Group (PPG) to represent patients and feedback their views of the practice to staff. The practice manager said they had tried to establish one by advertising for members in the practice waiting area however they had few responses. We saw during our inspection that the practice was continuing to advertise for patients to establish a PPG although they had not advertised on their website to maximise their audience.

Access to the service

Patients said they could get an appointment when they needed one and were confident that they would be seen appropriately in an emergency. The results of the National Patient survey 2013 showed that the practice scored above the CCG average for ease of getting through to the practice by telephone and the time patients had to wait after their appointment time to be seen by a GP. Surgeries ran from 9-11am and 4-6.30pm Monday to Friday. The practice operated extended hours on Mondays from 6.30pm to 7.30pm for patients who were unable to attend during normal working hours. Nurse appointments were also available daily. If urgent, patients could telephone or walk in to the practice from 8:15am to book an appointment for the same day or the next morning. Pre-bookable appointments could be made up to a month in advance. There was no online appointment booking system at the time of our inspection. The practice had a website with all the necessary information on the services provided by the practice.

Telephone advice was available daily and home visits carried out for patients who were housebound. An out-of-hours doctors service was available for patients who needed to see a GP when the practice was closed. Repeat prescriptions were available within 48 hours.

There was an interpreter service available for patients whose first language was not English to help them with their communication needs and a sign language service for patients who had hearing difficulties. However, we found that although there was a British Sign Language (BSL) service available for those patients with hearing difficulties reception staff were not aware of how to access it. The practice also had a hearing loop at reception that was not working.

Concerns and complaints

The practice had a complaints procedure in place. The procedure was available at reception on request but it was not displayed in the practice for patients to view. The practice had received five complaints in the previous year and they had been investigated and resolved in line with their procedure. The practice had not received any complaints in the current year. There was evidence that the practice reviewed complaints in staff meetings to ensure

Are services responsive to people's needs?

(for example, to feedback?)

learning was shared. However, we found that 17 negative comments had been left by patients on the NHS Choices website over a four year period. The practice had not responded to any of these comments.

Are services well-led?

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

Our findings

The service was not well-led.

The practice had some systems in place to monitor the quality of service provided. However we found that the practice did not have an active Patient Participation Group (PPG) to represent patients and feedback their views of the practice. We also found the practice had not completed an internal patient survey since before 2011, there was no suggestion box for patients to comment on the service and there was no opportunity for patients to leave their comments on the practice website.

Leadership and governance arrangements were in place. Staff were aware of their roles and responsibilities and who to report to if they had any issues.

Leadership and culture

The practice had two GP partners, one of whom had recently joined the practice. The senior partner was planning to retire in the near future although a specific date had not been decided. A succession plan was in the process of being formulated which involved the new GP partner taking over the running of the practice. The senior partner was the clinical lead and was delegating more responsibility to the new partner. The GPs were supported by a practice manager. The strategy of the practice was to build an extension to the practice to meet the demand of an increasing number of patients registering with the practice.

Governance arrangements

There were governance policies in place and staff were aware of their roles and responsibilities in relation to governance. Staff were clear on who was responsible for making specific decisions and who to report to if they had any issues or concerns. Staff had designated lead roles for various aspects of the service, including lead roles for safeguarding and infection control. Staff said they were supported in their job role and worked as a team.

Systems to monitor and improve quality and improvement

The practice used their Quality and Outcomes Framework (QOF) performance to identify areas for improvement. For example based on QOF performance the practice had reviewed patients with heart failure to improve outcomes for them. All the GPs had completed clinical audits and shared the results to improve outcomes for patients. The practice regularly reviewed complaints to ensure the service was improved where necessary.

Patient experience and involvement

The practice did not have a Patient Participation Group (PPG) to represent patients and feedback their views about the practice. The practice manager said they had tried to establish one through advertisement but there were few responses. The practice had carried out a 'snapshot' survey prior to our inspection and most of the comments were positive. However, the practice had not carried out a comprehensive patient survey since before 2011, there was no suggestion box for people to comment on the service and there was no opportunity for patients to leave their comments on the practice website. We also found that the practice had not responded to negative comments on the NHS Choices website.

Staff engagement and involvement

The practice did not have a Patient Participation Group (PPG) to represent patients and feedback their views about the practice. The practice manager said they had tried to establish one through advertisement but there were few responses. The practice had carried out a 'snapshot' survey prior to our inspection and most of the comments were positive. However, the practice had not carried out a comprehensive patient survey since before 2011, there was no suggestion box for people to comment on the service and there was no opportunity for patients to leave their comments on the practice website. We also found that the practice had not responded to negative comments on the NHS Choices website.

Learning and improvement

The practice had arrangements in place to learn from serious incidents, accidents, complaints and clinical audit. Learning was shared through internal meetings and improvements made to the service as a result. Learning was also shared externally through locality group meetings and peer review.

Identification and management of risk

The practice had an up to date business continuity plan to assess the potential risk to patients and ensure continuity of care in the event of a major disruption to the service.

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 services for older people including a new enhanced service to reduce unnecessary emergency admissions to secondary care, annual reviews for patients with dementia and regular meetings with the palliative care team to provide appropriate end of life care.

The practice provided services for older people. For example the practice was providing a new enhanced service to reduce unnecessary emergency admissions to secondary care by producing personalised care plans for at risk patients. All over 75 year olds had a named GP who was accountable for the patients care and treatment. Those who were more vulnerable could contact the practice and speak with their named GP to discuss a problem or request a home visit. Older patients on the dementia register were reviewed by the practice nurse and had annual blood checks. Regular meetings were held with the palliative care team from the local hospice to provide appropriate end of life care.

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 some services to patients with long term conditions including reviews of patients managing diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Elderly patients with long term conditions had been reviewed to reduce the likelihood of hospital admission.

The practice provided services to patients with long term conditions. Services included reviews for patients who had diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). The practice had identified 80 elderly patients with COPD, diabetes and cancer and patients suffering from dementia. These patients had been invited to the practice for a care plan review to reduce the likelihood of hospital admission.

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 services for mothers, babies, children and young people. Services included child immunisations, contraceptive clinics, antenatal and postnatal checks. The practice had recently started offering implants and intra-uterine contraceptive devices to patients which was proving popular with patients.

The practice provided services for mothers, babies, children and young people. For example routine antenatal check-ups were available by the community midwife on Tuesdays and health visitor clinics for expectant mothers and small children. The practice offered postnatal checks for mothers and six week checks for babies and letters were sent out inviting mothers and babies to attend. Child vaccinations were available through the practice nurse and systems were in place to recall children whose immunisations were not up-to-date. GPs with a paediatric query could contact Lewisham hospital and speak with the on-call paediatrician for advice. The practice have recently started a contraceptive clinic including implants and intra-uterine contraceptive devices which were proving popular with patients.

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 services for working age people including health screening services and an extended hours clinic on Mondays. Appointments could be booked in advance to fit around patients' working day and telephone consultations available daily.

The practice provided services for working age patients. This included a health screening service for patients aged 40-74. Patients falling outside this age range were also provided with health screening on request and newly registered patients were automatically screened by the practice nurse. Same day appointments available for working age patients and they could also book an appointment in advance to fit around their working day. The practice held an extended hours clinic every Monday 6.30-7.30pm and telephone consultations were available daily.

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 services to people in vulnerable circumstances including access to the practice for patients who were homeless or had a temporary address and regular health checks for patients with learning disabilities to improve outcomes for them.

The practice provided services to people in vulnerable circumstances who may have poor access to primary care.

The practice had 11 patients registered with learning disabilities and these patients were reviewed regularly by the practice nurse and referred to the GPs for treatment when required. The practice did not put up barriers to people in the community with no fixed abode. The practice registered patients who were homeless and patients with temporary addresses so they had access to healthcare services when needed.

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 supported patients experiencing poor mental health including annual health checks by the practice nurse. The practice worked with community health workers to improve outcomes for patients and made best interest decisions for patients who lacked capacity when necessary.

The practice supported 75 patients experiencing poor mental health living in two local care homes. These patients were seen regularly by the GPs and had annual physical checks by the practice nurse. GPs have an emergency link number to contact a community mental health worker to support patients seen at the practice experiencing poor mental health. The practice worked with carers and relatives to make best interest decisions for patients who lacked capacity in accordance with the Mental Capacity Act 2005.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because there were not adequate systems in place to engage with patients to obtain their views and opinions of the service. Regulation 10 (1) (a) (2) (b) (1)**