Crown Dale Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is a report of the inspection of the practice which we carried out on 26 November and 3 December 2014. The inspection was planned to check whether the practice 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. The practice had not been inspected before and that was why we carried out this comprehensive inspection.

We rated the practice as 'Good' in the five domains relating to it being safe, effective, caring, responsive and well-led. We also rated it as 'Good' for the care provided to all six population groups we looked at, including older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients' needs were assessed and care was planned and delivered in line with current guidance and legislation, including assessing capacity and promoting good health.
- Patients were treated with kindness, dignity and respect and they were involved in decisions about their care and treatment.
- The practice reviewed the needs of its local population and was responsive to patients' views.
- There were systems in place to monitor and improve quality and to identify and manage risk.
- The practice had effective infection control systems and staff received suitable infection control training.
- The practice had a clear vision and strategy and a stated commitment to provide and improve best care for patients and attain the highest standard of clinical practice.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.
- Staff members were properly supported to provide good patient care and improve outcomes for patients.

We identified an example of outstanding practice, resulting in improved outcomes for patients. An audit of hospital admissions from one of the care homes to which the practice provides a service led to the introduction of a process of staff reflection on whether the admissions were avoidable. The process was adopted by other care homes across the borough and data showed hospital admissions had reduced as a consequence.

In addition, we noted an example of good practice, again leading to improved patient outcomes. Staff monitored the results of the National Patients Survey 2014. As a consequence of patients' comments regarding opening hours, the ease of getting through to the surgery by phone and the experience of making an appointment, the practice will be introducing a new phone system in early 2015 and had reviewed its appointments system, resulting in the release of 200 more appointments per week.

However, there was also an area of practice where improvements should be made. Although we found that staff had received most of the training appropriate to their roles and that future training needs had been identified and planned, we were not shown evidence that all staff had received necessary training in child protection or safeguarding vulnerable adults.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff members to keep people safe.

The premises were clean and tidy. The practice had effective infection control systems and staff received suitable infection control training. Equipment was properly maintained. There were appropriate arrangement to deal with emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice made use of audit tools, supervision and meetings to assess staff performance. Policies and procedures guidelines were reviewed and updated regularly and staff members were made aware of any changes.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with dignity and respect. Patients were positive regarding the emotional support given by the practice and told us they were involved in decisions about their care and treatment. Information regarding the services provided was available and easy to understand. We saw that staff treated patients with kindness and respect and systems were in place to maintain confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure

Summary of findings

improvements to services where these were identified. The practice had an active Patient Participation Group (PPG), whose representatives told us that the practice was responsive to patients' views.

Patients were encouraged to make suggestions. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice had reviewed and made changes to the appointment process in response to patients' suggestions.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. The practice's business plan included a commitment to provide and improve best care for patients and attain the highest standard of clinical practice. Staff members were clear about the vision and their responsibilities in relation to this. 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 governance meetings. There were systems in place to monitor and improve quality and identify risk.

Staff received regular supervision and appraisals and attended staff meetings Staff members told us they felt involved to improve outcomes for patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people. Practice nurses carried out holistic healthcare assessments of older people. The practice provided a service to three local care homes and a specialist care unit. It offered a range of services including palliative and end of life care. It was responsive to the needs of older people, maintaining registers of those patients over-65 years old, who were housebound or who had had no contact with a GP for 15 months and of all patients over-80 years old. It offered home visits for those patients who were not able to attend the surgery.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice kept a register to monitor the health of patients with known long-term health conditions, such as chronic obstructive pulmonary disease. The practice provided a borough-wide service to people with diabetes. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication 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.

Families, children and young people

Good

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, children who had frequently missed appointments and those with identified health conditions such as asthma.

The practice was on course to meet its annual targets relating to childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Good

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. For example telephone consultations were available and extended hours offered a wider choice of appointment times. Patients could use the Choose and Book system to make appointments and repeat prescriptions could be ordered on line.

The practice had walk-in sexual health clinics late on Wednesdays and on Saturday mornings. Patients not registered with the practice could attend.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice maintained registers of patients living in vulnerable circumstances, such as those with learning disabilities, and a register of carers so that patients' healthcare needs could be monitored and reviewed. The practice had carried out annual health checks for a number of patients on the learning disabilities register and had a clear plan to complete health checks for the remainder of the patients before April 2015.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to inform staff of any relevant issues when patients attended appointments, for example patients with limited capacity.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff members were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice provided a service to a number of local care homes and a specialist care unit with GPs visiting them 2-5 times a week. The practice regularly worked with multi-disciplinary teams in the case management of people in this population group. The electronic record system would flag up if vulnerable patients were attending for an appointment so that staff members were aware of any relevant issues.

Summary of findings

What people who use the service say

We spoke with seven patients during the course of our inspection, together with a representative of the Patient Participation Group (PPG). We reviewed 29 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. We looked at information published on the NHS Choices website, the results of the practice's most recent patient experience survey and the National Patient Survey 2014.

The evidence from all these sources showed patients were satisfied with their GP practice in terms of the practice being caring. Patients said they were generally treated with dignity and respect by the practice staff, although a few had concerns over how some reception staff dealt with them. Patients said their privacy was respected and that the clinical staff involved them in decisions about their care and treatments.

We noted a number of comments made by patients using the NHS Choices website regarding their dissatisfaction with making appointments and contacting the practice by telephone. However, patients told us that things had improved since the practice had introduced a new appointments system in May 2014. Other comments received from patients were highly complementary of the clinical care provided by the practice.

Areas for improvement

Action the service SHOULD take to improve

Ensure that all staff members receive appropriate level training in child protection and safeguarding vulnerable adults.

Outstanding practice

We identified an example of outstanding practice, resulting in improved outcomes for patients.

An audit of hospital admissions from one of the care homes to which the practice provides a service led to the introduction of a process of staff reflection on whether the admissions were avoidable. Following the audit, the practice drew up an "admissions avoidance sheet" to be used by care home staff to reflect on whether hospital admissions had been avoidable. The reflection process had since been adopted by all care homes across the borough working with local Care Commissioning Group (CCG). The CCG collects data on hospital admissions from care homes and reports monthly to practices. The data showed that in the five months since the audit and the introduction of the reflection process, hospital admissions from the care homes had reduced to 139, compared to 153 in the same period in 2013.

Crown Dale Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspection Manager. It included a CQC Inspector, a GP and an expert-by-experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. They were all granted the same authority to enter Crown Dale Medical Centre as the Care Quality Commission (CQC) inspectors.

Background to Crown Dale Medical Centre

Crown Dale Medical Centre operates from 61 Crown Dale, Upper Norwood, London SE19 3NY. The practice provides NHS primary medical services through a Primary Medical Services (PMS) contract to approximately 10,400 patients in Norwood, South London. The practice is part of the NHS Lambeth Clinical Commissioning Group (CCG) which is made up of 48 general practices. It is a teaching practice, assisting in the training of a number of trainee doctors.

The practice serves a wide population group with more over-65s than the borough average. The practice staff was comprised five GP partners and six salaried GPs, of whom six were female doctors and four male. One of the male GP partners was due to retire around the time of our inspection. Three trainee doctors were working at the practice. There were three practice nurses, one health care assistant, one phlebotomist (responsible for taking blood samples) and four specialist diabetic nurses, all female. Two counsellors and a drug and alcohol worker operated at the practice and there was an attached midwife. The practice had not had a practice manager for most of the past year, but one had been appointed and was due to start work in January 2015.

The practice opening hours are 8.00am to 6.30pm on Monday to Friday. There are extended hours until 8.30pm on Wednesdays for pre-booked appointments and a walk-in sexual health clinic. The practice is also opened from 9.00am to 12.00 noon on Saturdays for pre-booked routine appointments and a walk-in sexual health clinic. The practice has opted out of providing out-of-hours (OOH) services to their own patients and refers callers to the local OOH service provider.

The practice is responsible for the providing intermediate diabetes healthcare services for the Lambeth CCG. It also provides general healthcare services to the residents of three local care homes and a specialist care unit.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS Choices website and the National Patient Survey and asked other organisations such as Healthwatch, NHS England and the NHS Lambeth Clinical Commissioning Group (CCG) to share what they knew about the service. We carried out announced visits on 26 November and 3 December 2014.

During our visit we spoke with a range of staff including four GPs, a practice nurse, two specialist diabetic nurses and two non-clinical staff. The newly appointed practice manager was also present and involved in the discussions. We spoke with seven patients who used the service and a representative of the Patient Participation Group (PPG). We reviewed 29 completed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

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.

Good

Are services safe?

Our findings

Safe Track Record

The practice had systems in place to identify risks. We saw the practice's significant / critical event toolkit, which set out a procedure and guidance for recording and reviewing events. Like the practice's other policies and procedures, it was reviewed annually. Staff told us of the accident reporting procedures and when they used the accident report book. The practice had a policy for dealing with national NHS patient safety alerts. These were received from the NHS central alerting system and passed to the duty GP, who circulated them to colleagues via email. We saw that they were discussed at clinical meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We were shown the practice's significant events summary log for the past year, which listed 10 incidents. We looked at two completed examples of significant event reporting forms. One related to a delay in a patient's referral and the other to a patient's prescribed medication. We saw that both events had been recorded, investigated and actioned appropriately. The summary log confirmed that other events were properly dealt with, reviewed at staff meetings and acted upon. We saw minutes of staff meetings which confirmed that learning from incidents was discussed and passed on.

Reliable safety systems and processes including safeguarding

We saw that the practice had up to date policies and procedures for protecting both children and adults from harm. There was a designated GP responsible for child protection and safeguarding adults. Most staff had completed child protection training to a level appropriate to their role. This included GPs being trained to level 3 and practice nurses to level 2. However, we were not shown evidence that two of the diabetes specialist nurses had received appropriate training. Most staff had received the required training in safeguarding adults, but the practice had no evidence to confirm that nine members of the clinical staff had been given appropriate training. The practice gave us an assurance that outstanding online refresher training would be completed by the end of February 2015.

Staff members were able to describe the reporting procedures if they had concerns about a patient. Contact details for the local area safeguarding team were kept with both the paper and electronic copies of the safeguarding policy and were posted throughout the premises. GPs attended child protection conferences and serious case review meetings whenever possible. If they could not attend, they sent in reports of their involvement and concerns. The practice held child protection meetings every three months to review on-going issues.

Staff were alerted to children and vulnerable adults on the at risk register through the practice's electronic record system. These were reviewed every two or three weeks. The electronic records system alerted staff when children and young people had a high number of hospital accident and emergency attendances. Such cases were discussed at the practice's monthly risk meetings. A member of the administrative staff was responsible for following up incidents of children's frequently-missed appointments, to which they were alerted by the electronic records system.

The practice's electronic system alerted GPs when patients aged over-65 years had not been seen for over 15 months. The patients were contacted and invited to attend a health check. We saw that the practice maintained a register of patients with learning disabilities, which allowed for patients' health action plans to be drawn up, agreed and monitored. The practice also maintained a register of carers, allowing for their health care needs to be monitored and reviewed.

The practice had a whistleblowing policy to protect patients, should staff have concerns about how the service was being delivered. Staff members were able to tell us of the whistleblowing procedures and how they would raise a concern.

A chaperone policy was in place, which staff members were familiar with and which was displayed for patients to view. Only clinical staff, who had undergone Disclosure and Barring Service (DBS) checks and received appropriate training, acted as chaperones. The system allowed patients to have a third party present during a consultation, or medical examination if they so wished.

Medicines management

We saw that the practice had an up to date policy relating to medicines management. We checked medicines stored in the treatment rooms and medicine refrigerators and

found they were stored securely and were only accessible to authorised staff. Medicines were kept at the required temperatures. The medicines we checked included emergency medication. There was a specific policy relating to the management of controlled drugs, but at the time of the inspection none were kept on the premises. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. These included patients' prescription reviews, repeat prescriptions and declined medication. We saw the practice's up to date policy on repeat prescribing and records of regular prescribing audits.

Vaccines were administered in line with legal requirements and national guidance. We saw that the staff responsible received annual update training in immunization.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with, and those who returned comments cards, told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw records confirming that staff received induction training about infection control specific to their role and had received annual updates. We saw that all staff were booked on refresher training to be provided in January 2015.

The practice carried out annual infection control audits and actions identified had been completed. We saw business meeting minutes, which confirmed that the findings of the last audit had been discussed and actioned, with staff being referred to the audit findings.

The practice had an up to date infection control policy and supporting procedures were available both as hard copies and on the practice's shared computer system for staff to refer to, so they could plan and implement measures to control infection. Suitable personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff told us how they would deal with spillages.

Notices reminding patients and staff of the need to disinfect their hands were displayed around the practice and there was an appropriate supply of hand gel dispensers.

We saw that the practice had arranged for a recent independent test and assessment relating to Legionella (a germ found in the environment which can contaminate water systems in buildings). The assessment had been carried out on the 23 October 2014. The recommendations of the report had been implemented.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw certificates and other records confirming that all equipment was tested and maintained regularly and if appropriate properly calibrated. All portable electrical equipment had been tested in line with requirements and displayed stickers indicating the last test had been carried out recently. A schedule of equipment testing was in place.

Staffing and recruitment

We saw the practice's recently-reviewed recruitment policy. Most of the staff had been employed by the practice for many years. Although some of the records relating to the long-serving staff were incomplete, we saw evidence that more recent staff appointments had been made in accordance with the recruitment policy and that appropriate pre-employment checks had been carried out. This included proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

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

Good

Are services safe?

enough staff members were on duty. We were told that rotas were planned and prepared two months in advance to cater for seasonal needs and ensure that staff members' leave was covered. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The records we saw indicated that the checks were undertaken every few months. The new practice manager told us they would be done on a monthly basis from January. The record showed that identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings and staff told us they knew they could raise matters of concern. For example, the results of a recent infection control audit had been discussed and circulated to all staff, with instructions to tidy all rooms.

We saw that the practice had a health and safety policy which had been recently reviewed. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice maintained various registers of patients with known long-term health conditions, such as chronic obstructive pulmonary disease, the work being co-ordinated by the multidisciplinary team. A member of the administrative staff was responsible for monitoring child patients with identified health conditions, such as asthma.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which showed all clinical staff had up to date training in basic life support and that courses had been booked for February 2015 for refresher training. We saw that emergency equipment, including a defibrillator was available, including access to oxygen. A training session for staff had been conducted on the 19 October 2014. When we asked members of staff, they all knew the location of this equipment. Records confirmed that it was checked regularly. Appropriate emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw that the practice had a suitable business continuity plan, covering a range of emergencies that might impact on the daily operation of the practice. The plan contained relevant emergency contact details for staff to refer to and set out details for the practice to continue to provide care at three nearby surgeries should its own premises be unusable for any reason.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. The practice had a policy for reviewing guidelines issued by the National Institute for Health and Care Excellence (NICE). Staff we spoke with were familiar with current best practice guidance and accessed the NICE guidelines and those from local commissioners and the General Medical Council. Staff told us that NICE guidelines were emailed to all members of the clinical team and discussed at referral meetings. Staff also told us that directives issued by the Lambeth Care Commissioning Group were emailed to clinical staff and discussed at partner' and clinical meetings. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as cancer, diabetes, heart disease, asthma, dementia and learning difficulties. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice computer system was used to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. We saw no evidence of discrimination when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. Staff told us how they would raise any concerns they had regarding discrimination.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included clinical governance, information governance, complaints, health and safety, infection control, safeguarding and the Mental Capacity Act 2005.

We saw that the practice carried out various regular clinical audits, which included medicines prescribing, patients with diabetes, and minor surgery. Staff used the computer system to run regular reports, such as hospital admissions, to monitor the service. We saw that the audits had been learned from and had led to changes in clinical practice. For example, following an audit in January 2014 of patients with chronic obstructive pulmonary disease (COPD) prescribed inhaled corticosteroids, six patients had their medication reduced. As a consequence of the audit, the clinical team had become more aware of the current guidelines for the management of COPD. When the patient group was re-audited in November 2014, the six patients remained on the appropriately reduced mediation and the audit showed that prescribing practice had changed. We noted the following example of outstanding practice. In May and June 2014, the practice carried out an audit of hospital admissions from one of the care homes receiving a service. As a consequence of the audit, the practice drew up an "admissions avoidance sheet" to be used by care home staff to reflect on whether hospital admissions had been avoidable. The reflection process had since been adopted by all care homes across the borough working with local Care Commissioning Group (CCG). The CCG collects data on hospital admissions from care homes and reports monthly to practices. The data showed that in the five months since the audit and the introduction of the reflection process, hospital admissions from the care homes had reduced to 139, compared to 153 in the same period in 2013. The continuous cycle of audit and reflection has now been put in place across the CCG, allowing GPs and care home teams to review hospital admissions. In this way any inappropriate admissions can be identified and lessons learned. We also saw the results of an audit of administrative and clinical aspects of minor surgery carried out at the practice. The audit highlighted that patient consent forms often lacked information relating to the procedure. It resulted in a revised, more detailed, consent form being introduced, which we saw was now in use. We saw that a re-audit of minor surgery was being planned.

Staff told us that clinical audits were often linked to medicines management information, safety alerts or as a

Good

Are services effective?

(for example, treatment is effective)

result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool, which is used to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. The practice used the QOF data to monitor its performance. The practice had scored positively in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014, achieving 100% in Patient Experience (equal to the CCG average) and Quality and Productivity results (being 0.1% above the CCG average). In relation to Public Health results, the practice achieved 96.3%, (0.3% above the CCG average) and for Clinical results, 84.2%, which was 9.2% below the CCG average. The practice had a Clinical exception rate 8%, 1.3% above the CCG average.

We were told that last year the data had shown a slight underperformance relating to flu vaccinations for patients over-65. This led to the practice introducing a new process of writing to patients and consolidating appointments to combine such matters as diabetes care and blood pressure checks enabling flu vaccinations to be given at the same time. We were shown evidence that the practice was on target to meet the 2014/15 performance standards.

A child immunisation/vaccination service was available and national guidelines were followed. Child immunisations were offered at the required one, two and five year intervals. Data showed that the practice had scored just above the CCG average for immunisations in the previous year.

We were shown evidence that the practice participated in the local CCG benchmarking exercise .The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Clinical staff told us that there was no formal system for peer reviewing each other's work, but they worked closely and routinely sought colleagues' opinions and advice.

We saw that the practice reviewed and updated its policies and procedure notes annually. Staff members were required to acquaint themselves with the updated guidance and complete a checklist to confirm they had done so.

The practice had a protocol for repeat prescribing, which was in line with national guidance. We saw that staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, they recorded the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal, as well as monthly multidisciplinary, meetings to discuss the care and support needs of patients and their families. Each patient on the register had a named GP, responsible for regularly reviewing their care.

The practice referred patients to secondary care and other community care services appropriately. The practice monitored the referrals. Urgent referrals for secondary care, such as suspected cancer, were monitored by each GP. Other referrals were monitored by a member of the administrative staff. The NHS Choose and Book system, which enables patients to book or change outpatient appointments online, provided the practice with monitoring information. All hospital discharge letters received were reviewed initially by the duty GP and then passed to patients' normal doctors to follow up.

We saw that the practice had a variety of information leaflets available in the waiting area offering advice on health promotion and prevention.

Effective staffing

The practice staff was comprised five GP partners and six salaried GPs, of whom six were female doctors and four male. One of the male GP partners was due to retire around the time of our inspection. Three trainee doctors were working at the practice. There were three practice nurses, one health care assistant, one phlebotomist (responsible for taking blood samples) and four specialist diabetic nurses, all female. Two counsellors and a drug and alcohol worker operated at the practice and there was an attached midwife. The practice had not had a practice manager for

Good

Are services effective?

(for example, treatment is effective)

most of the past year, but one had been appointed and was due to start work in January 2015. We reviewed a number of staff files including both clinical and non-clinical staff. They demonstrated that staff had the appropriate skills and qualifications to meet patients' needs. The GPs were licenced by the General Medical Council (GMC) and the nurses registered with the Nursing and Midwifery Council (NMC). All staff had received regular mandatory training in a wide range of topics. Topics included health and safety, equality and diversity, basic life support, child protection, safeguarding adults, infection control, information governance and computer training.

All staff had completed annual appraisals. The appraisal cycle included objectives for staff to achieve within a specific timeframe. Staff told us they had regular supervision meetings and were actively encouraged to develop and contribute to their personal development plans. The GPs were up to date with the General Medical Council (GMC) requirement for revalidation.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X-ray results, and letters from local hospitals, including discharge summaries, from the out-of-hours service provider, both electronically and by post. Incoming communications were passed initially to the duty GP to review and action as appropriate. All staff we spoke with understood their roles.

During the inspection, we asked to see the practice's system for receiving patients' results. Tests were booked and the results returned using the practice's electronic system. We noted 13 abnormal blood test results which appeared not to have been followed up. We discussed this with the practice staff, who investigated the matter straight away. It was found that the results had been returned to the system inboxes of trainee GP who had been training with the practice, but who had left before the tests were requested. The tests had in fact been requested by another service, using the same electronic system, which records the test requests in the name of patients' GPs. The other service had viewed and actioned the test results themselves. Following a thorough review of the patients' records, practice staff told us that the patients concerned had been followed up within two weeks of the tests results being known. There was no evidence of any adverse patient outcomes. The practice raised the matter appropriately as a significant event. The investigation revealed shortcomings in the way the electronic system had been set up and the training staff had received in its use. A suitable action plan was put in place.

The practice had been commissioned to provide enhanced services and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for dealing with hospital discharge communications was working well in this respect. Hospital discharge letters were received and processed by administrative staff and passed to the duty GP. If no immediate action was needed, the letters were passed to the patient's named GP to follow up as appropriate.

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

Information sharing

The practice used electronic systems to communicate both between colleagues and with other providers. Special patient notes were shared with the out-of-hours service provider. Special patient notes are information recorded about patients with complex health and social care needs and who may be at risk to themselves or others. When patients were referred by the practice to A&E, summary notes were provided.

The practice made use of the Choose and Book system, which enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital. We saw that for the year 2013/14, 1,322 referrals had been made using the system, together with 845 first outpatient appointments.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We saw that the practice had up to date policies on patients' consent to treatment. It contained guidance on both the Gillick competencies and Fraser guidelines, used to obtain consent from children under 16 years old to their own medical treatment without the need for parental permission or knowledge.

There was separate guidance on the Mental Capacity Act 2005 and assessing patients' capacity to consent. There was an identified member of the clinical staff leading on issues relating to the Mental Capacity Act. Patients with learning difficulties or dementia were supported to make decisions regarding their healthcare. Decisions were recorded in their care plans, which were reviewed annually. We found that members of staff were aware of the Mental Capacity Act 2005 for example when recording patients' choices regarding Do Not Attempt Resuscitation (DNAR) instructions.

We saw that patients' consent to cryosurgery, a treatment by which certain types of skin lesions can be frozen, was recorded appropriately. The practice used a written consent form covering minor incision surgery, which contained further guidance on patients', including children's, capacity to consent to treatment.

Staff told us that there had been no instances where the use of restraint techniques was needed. Staff had been trained in dealing with challenging behaviour.

Health promotion and prevention

The practice provided a range of health promotion services including an antenatal and post natal clinics, baby clinic and child immunisation, flu and travel vaccination, asthma, sexual health, osteopath and smoking cessation. It provides intermediate diabetes healthcare services for the whole of the Lambeth CCG. New patients could complete a pre-registration form and medical questionnaire allowing staff to make an early assessment of their healthcare needs. Practice nurses carried out holistic healthcare assessments for older patients, both at the surgery and at the patient's home, if they were housebound.

The practice offered influenza vaccinations to all patients identified at risk. However, it had identified that the take up of vaccinations had not been as much as hoped for. Figures showed that 65% of people aged over 65 had received vaccinations, whilst 43% of people aged-65 and in at risk groups had been vaccinated. In total, 9% of people in the target groups had declined an offer of vaccination. The practice was planning measures to increase the numbers of vaccinations given in future. These included increasing the number of walk-in clinics, spreading these over a 3 month period (October - December) and having additional sessions on some evenings and Saturday mornings. A "flyer" advertising walk-in clinics is to be attached to all repeat prescriptions from September 2015, with information being posted in the waiting area and on the practice's website regarding the clinic and highlighting the importance of flu vaccination. Bookable appointments will be available to patients who are not able to attend walk-in sessions and all clinicians would take the opportunity to offer vaccinations during general appointments. Patients who were resident in the care homes serviced by the practice, together with care workers were specifically targeted with offers of flu vaccinations. Child immunisations were offered at the required one, two and five year intervals and national guidelines were followed. We saw evidence that the practice was on course to meet its annual targets.

The practice had a register of 44 patients with a learning disability. We saw data indicating that 13 patients had so far received their annual physical health check. We were told the remainder would have their checks done before April 2015.

We saw that the practice had a variety of information leaflets available in the waiting area to help patients make informed decisions about their care and treatment. Some of these were available in languages other than English. The practice website contained links allowing people for whom English is an additional language to access information regarding healthcare service.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Patient Survey, NHS Choices feedback, and patients we spoke with during our inspection. Patients also completed Care Quality Commission (CQC) comment cards to provide us with feedback on the practice.

The evidence from all these sources showed that most patients were satisfied with their GP practice in terms of the practice being caring. This was reflected in the National Patient Survey 2014 where 80% of respondents described their overall experience of the practice as 'fairly good' or 'very good'.

All seven patients we spoke with said they were treated with dignity and respect by the practice staff and their privacy was respected. Some patients mentioned a lack of privacy when discussing issues with reception staff. We saw that a printed form was available for people to complete and hand in if they did not wish to discuss their health. They could then be accompanied by a receptionist to a private room. We received 29 completed cards and the majority were positive and said the staff members were empathic to their needs. This was reflected in the National Patient Survey 2014 which showed the practice scored in line with the national figures with 85% of patients saying the last time they saw or spoke to a GP they were treated with care and concern.

Patients said that all consultations and treatments were carried out in the privacy of a consultation room and their private conversations could not be overheard. Disposable curtains were provided in consultation and treatment rooms to maintain patients' privacy during examinations and treatments.

Care planning and involvement in decisions about care and treatment

Patients said the clinical staff involved them in decisions about their care and treatments and this was reflected in the comment cards we received. The results of the National Patient Survey 2014 showed the practice scored in line with national figures with 77% of patients saying the last GP or nurse they saw or spoke to was good at involving them in decisions about their care.

Patients said that clinical staff sought their consent before carrying out physical examinations. Patients said the GPs discussed treatment options including the pros and cons of different treatments before a decision was made about their treatment or care. GPs were able to demonstrate an understanding of Gillick competency assessments of children and young people. Gillick competency guidelines help clinicians decide whether a child under 16 years has the legal capacity to consent to medical examination and treatment without the need for parental permission or knowledge.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were positive about the emotional support provided by staff at the practice. GPs were described as being compassionate and helpful and we were told that they spend much time building relationships. This was reflected in the CQC comment cards we received, with patients saying GPs were always listening and were very supportive.

The practice had systems to ensure that known relatives and carers were contacted after a person had died. The practice maintained a palliative care register listing patients with a terminal illness. All patients on the register had a named GP and their care was discussed at monthly multi-disciplinary team meetings. Staff told us it was the routine that the GP involved in a patient's care contacted the relative or carer by telephone, or make a home visit, after a death has occurred. Staff said that the practice was generally informed in writing within 24 hours of a patient dying in hospital and that GPs often made contact with relatives once the practice had been informed. All deaths were discussed at the end of practice palliative care meetings and all staff members are informed of any death, so that they have heightened awareness should a relative contact the practice. Most of the GPs had received training in advanced care planning.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We had seen from patients' comments on the NHS Choices website that there had been problems in obtaining convenient appointments. This had been reflected in the results of the National Patients Survey 2014, where the practice had scored below the regional average for patients' experience of making appointments, the ease of contacting the practice by phone and getting to see or speak with their preferred GPs. Some of the patients we spoke with and some of those who had returned comments cards also said that contacting the practice by phone and making appointments had been a problem, but acknowledged that the process had improved. We were told that a new phone system would be introduced in early 2015. Due to the comments, the practice had introduced a new booking system in May 2014. This allowed for most appointments to be bookable in advance. Furthermore, the duty GP was available to speak with on the telephone every day if the problem was urgent. In addition, on three mornings a week there was an additional GP triaging urgent problems to ensure those with the greatest need were seen that day. One GP surgery operated on Saturday mornings, with two GP surgeries on Wednesday evenings, together with a practice nurse clinic at the same time. Home visits were available for those patients who were housebound.

The practice had a Patient Participation Group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with a representative of the PPG who explained their role and how they worked with the practice. The PPG had been less active during the absence of the practice manager. However, there was regular contact between the PPG and the practice, which had been very responsive to patients' views. We saw the minutes of the PPG meetings held in April and May 2014. Suggestions for improvement made by the PPG had been actioned by the practice. For example the practice had arranged for a handrail to be fixed to an access ramp, following a request by the PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice provided annual health checks for patients with learning disabilities. Information regarding NHS services was available in the waiting area and the practice website had access to translation links. An interpreter service was available for patients whose first language was not English. In accordance with the Southwark and Lambeth Integrated Care older peoples programme, the practice had established registers of patients aged over-65 and who were housebound and who had had no contact with a GP for 15 months and of all patients aged over-80. The practice also maintained a register of patients with learning difficulties. These registers enabled the practice to monitor and meet patient's health care needs.

The premises had been identified as being too small for the practice's current needs. Discussion was on-going with the local NHS, who owns the premises, regarding identifying possible alternatives. Some adaptations had been made to meet the needs of people with disabilities, but access for wheelchair users was restricted due to a step at the front entrance and a narrow entrance hall at the rear, which opened into the administrative office. Further possible adaptations were limited.

We found staff had completed training in equality and diversity.

Access to the service

We saw from the results of the National Patients Survey 2014 that the practice did not score well for opening hours, the ease of getting through to the surgery by phone and the experience of making an appointment. As a consequence, the practice will be introducing a new phone system in early 2015 and had reviewed its appointments system, resulting in the release of 200 more appointments per week. We considered this an example of good practice.

The practice opening hours were 8.00am to 6.30pm Mondays and Fridays. There were extended hours on Wednesdays until 8.30pm for pre-booked appointments with 2 GPs or a practice nurse. The practice also opened on Saturday mornings for pre-booked appointments with a GP between 9.00am and 10.30am. The GP then conducted a walk in sexual health clinic until 12.00 noon. Also on Saturdays a practice nurse ran a sexual health clinic between 9.30am and 11.45am. The sexual health clinics were open to both registered and non-registered patients.

We were told of plans to introduce a new telephone system early in 2015, which would improve patients' experience of

Good

Are services responsive to people's needs?

(for example, to feedback?)

contacting the practice. Patients could also use the Patient Access system to book an appointment, or order repeat prescriptions, although they were required to register with the service beforehand.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by the local out-of-hour's service provider. Information on the out-of-hours service was provided to patients on the practice's website and in notices at the premises.

Listening and learning from concerns & complaints

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

The practice's website informed patients how to submit suggestions and complaints. A complaints leaflet was held at reception. We saw that six complaints had been submitted during 2014. The complaints indicated no particular trend or cause for concern. We saw that they had been dealt with appropriately, in line with the practice's complaints policy. We saw that complaints were discussed at team meetings and shared with staff. We also saw that the practice had responded to two negative comments by patients on the NHS Choices website The new practice manager told us that the practice would be more proactive in responding to comments in future.

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

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's business plan for 2014-2018. The practice vision and values included a commitment to provide and improve the best care for patients, to attaining the highest standard of clinical practice and encourage health promotion and maintain comfort and a supportive working environment for all staff.

Staff we spoke with told us of the happy working environment and of their commitment to the practices stated plans and values.

Governance arrangements

The practice had a large number of policies and procedures in place to govern activity and these were available to staff both in paper copies and on the practice's shared computer drive. We saw that the policies were reviewed annually. Staff members were required to acquaint themselves with the policies and sign a form confirming they had read them.

There was a clear leadership structure with named members of staff in lead roles. For example, partners were leads for areas such as clinical governance and health and safety, whilst a practice nurse was responsible for infection control. Staff members we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an on-going programme of audits which it used to monitor quality and systems to identify where action should be taken. These included infection control audits, minor surgery, long acting reversible contraception, prescribing and patient groups, such as those with chronic obstructive pulmonary disorder. We saw that the results of the most recent infection control audit had been discussed at a business team meeting and the results of a prescribing audit had been presented and discussed at a clinical meeting in April 2014, with recommendations for improvement.

The practice held various governance meetings, including clinical, partners' and business meetings. Staff groups, such as the administrative team also met on a regular basis. We saw from minutes that performance, quality and risks, as well as specific topics, such as flu vaccinations and bowel screening were discussed and actioned appropriately.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We reviewed a number of policies relating to human resources management, such as disciplinary and grievance procedures, recruitment, staffing, equalities issues and stress, harassment and bullying, which were available to support staff. Staff we spoke with told us they were familiar with the policies and had access both to paper copies and those stored on the practice's shared computer drive.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients using patients' surveys, comments and suggestions and complaints. We saw the results of a general survey of patients' carried out in October 2013, another for patients attending the diabetes clinics between July and October 2014 and one for people attending the sexual health clinics. We saw that issues raised in the general survey, such as problems in obtaining convenient appointments, had been actioned by trialling a telephone triage system in May 2014. We noted that patients' satisfaction rates in both the diabetes and sexual health clinics survey were very high.

The practice had a patient participation group (PPG). We saw an analysis of the last patient survey, which was considered in conjunction with the PPG. A representative of the PPG that we spoke with was very positive in their view of the practice and said the PPG was very much involved.

Staff members were able to provide feedback at team meetings and at supervision and appraisal sessions. Staff told us they would not hesitate to give feedback and

Are services well-led?

Good

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

discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which staff members told us they were aware of.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. Partners mentored salaried GPs and nurses were supported by the local practice nurse network.

The practice was a GP training practice, with several trainees in training at any one time. The registrars sat in on consultations with patients' permission.

We saw that the practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.