# Sternhall Lane Surgery

## Quality Report

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Website: http://sternhalllanesurgery.co.uk/

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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 |

# Key findings

## Contents



## Letter from the Chief Inspector of General Practice

**This practice is rated as Good overall.** (Previous inspection 11 July 2017 – the practice was rated as Requires improvement.)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Sternhall Lane Surgery on 9 August 2016. The overall rating for the practice was requires improvement. As a result of our findings from this inspection CQC issued a requirement notice for the identified breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a further announced comprehensive inspection on 11 July 2017 to follow up on the breaches of regulations and areas of improvement identified. While most of the issues leading to the breaches in August 2016 had been resolved, further concerns were identified in relation to infection control, medicines management and governance systems. Overall the practice remained rated as requires improvement and CQC issued a requirement notice for the breach of Regulation 17 and a warning notice for the breach of regulation 12.

The full comprehensive reports for the previous inspections in 2016 and 2017 can be found by selecting the 'all reports' link for Sternhall Lane Surgery on our website at www.cqc.org.uk.

This inspection was undertaken within six months of the publication of the last inspection as the practice was rated as inadequate for one of the key questions; are services safe? This inspection was an announced comprehensive inspection on 14 March 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was to follow up on the breaches of regulations 12 and 17 and areas of improvement identified from the last inspection, in line with our next phase inspection programme.

At this inspection we found:

# Summary of findings

- The practice had clear and improved systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice had improved the management of prescriptions and results so they were safe.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The practice had implemented a number of systems to ensure that staff had the skills and knowledge to provide effective care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Complaints were investigated and responded to openly and thoroughly and information about how to make a complaint was easily accessible for patients.
- There was a positive and open culture and staff felt supported by the practice leaders; systems for cascading information to staff had improved.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to engage with the premises owner regarding premises improvements.
- Work to increase the uptake of breast and bowel screening and improve child immunisations in areas that are below the national target.
- Review how the Patient Participation Group can be used to improve the service delivered.

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

# 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 |
| **People with long term conditions** | Good |
| **Families, children and young people** | Good |
| **Working age people (including those recently retired and students)** | Good |
| **People whose circumstances may make them vulnerable** | Good |
| **People experiencing poor mental health (including people with dementia)** | Good |

# Sternhall Lane Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector. The team included a second CQC inspector, a GP specialist advisor and an expert by experience.

## Background to Sternhall Lane Surgery

The registered provider of the service is Hurley Clinic Partnership. The address of the registered provider is Hurley Clinic, Ebenezer House Kennington Lane, London, SE11 4HJ. The practice is registered as a partnership of three partners with the Care Quality Commission to provide the regulated activities of diagnostic and screening services, family planning services, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury. Three further partners are due to apply to be added to the provider's registration.

Regulated activities are provided at 16 locations operated by the provider, including Sternhall Lane Surgery. The practice website is http://sternhalllanesurgery.co.uk.

Sternhall Lane Surgery provides services to 5800 patients in Peckham, South London and is one of 38 member practices of Southwark Clinical Commissioning Group (CCG). The practice provides services to two care homes and a local detox rehabilitation facility.

The practice has a higher than national average population of those of working age and a higher than average number of those over 65 for England. There is a lower than average percentage of children aged 5-14. Deprivation scores are higher than local and national averages for older people and higher than national average for children. The practice is in the 3rd most deprived decile in England. Of patients registered with the practice, approximately 50% are White or White British, 34% are Black or Black British, 8% are Asian or Asian British, and 8% are other or mixed ethnic backgrounds.

Sternhall Lane Surgery operates from a converted residential property which is owned by a previous GP contract holder. Due to ongoing premises upkeep issues, the practice has liaised with the CCG and a business case has been submitted to relocate the practice to more suitable premises. The surgery is accessible to those with mobility problems.

Of the three partners due to be added to the provider's registration details, one male partner works at Sternhall Lane Surgery as the lead GP. There are two part time female salaried GPs and a long-standing part time female locum GP. There is a part time female salaried GP providing sessions to the two care homes registered with the practice. In total the practice provides 33 doctor sessions per week; 23 at the practice and 10 specifically for the care home patients.

There is a further part time female salaried GP who solely provides one session at the local substance misuse rehabilitation facility.

There is one full time practice nurse and a part time health care assistant. The non-clinical team includes the practice manager, the patient services manager, two administrative staff and three reception staff. Managerial support is provided from the Hurley Clinic Partnership business manager and the local regional manager.

Good

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as good for providing safe services.**

**Safety systems and processes**

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff, including locums.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding training appropriate to their role. It was practice policy that nurses and doctors were trained to level 3 in safeguarding children and adults. All staff we spoke to knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Most staff had undertaken training in Prevent Duty, to improve awareness and recognition of radicalisation among their patient population.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice conducted or arranged for a number of safety risk assessments on an annual and monthly basis. During the inspection we found that although health and safety was regularly assessed, not all health and safety risks had been identified by the current risk assessment processes, including the absence of an emergency alarm in the disabled access toilet and the presence of a number of long blind cord loops in clinical rooms. The practice put measures in place immediately following the inspection including a thorough health and safety risk assessment of the whole premises and a blind loop cord risk assessment, which resulted in removing some blinds and purchasing blind clips in order to mitigate the risks. The practice also installed an alarm system in the disabled access toilet.
- The practice had a number of systems in place to ensure that facilities and equipment were safe. Equipment was tested for electrical safety and maintained according to manufacturers' instructions.
- The practice had some arrangements for the control of substances hazardous to health (COSHH) including safely storing cleaning substances, and keeping a record of data sheets pertaining to hazardous products stored. However, there were no other formal COSHH systems in place. The practice implemented a practice COSHH policy and undertook a risk assessment immediately after the inspection.
- There was a range of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.
- There was an effective system to manage infection prevention and control. At the previous inspection in July 2017, we found that the practice had not completed an infection control audit within the last 12 months. During this inspection we saw that an infection control audit had been undertaken in November 2017 by NHS England and all actions identified by the audit had been completed including improving seals between floors and skirting and ensuring staff immunisation and immunity records were updated. Although the premises required some updating to align with infection prevention and control guidance, the practice were unable to engage the owner of the premises to make the necessary improvements. The practice had submitted a business case to the local Clinical Commissioning Group (CCG) to relocate the practice to more suitable premises locally.
- Staff had received annual infection control training. The practice nurse was the infection control lead; the practice provided evidence they were securing infection control lead training for the nurse after the inspection.
- There were systems for safely managing healthcare waste.

**Risks to patients**

There were adequate systems to assess, monitor and manage risks to patient safety.

Good

# Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- The majority of GP sessions were provided by permanent GP staff, however where the practice employed locum GPs, these were from a pool of regular Hurley Clinic Partnership locum staff, familiar with the running of the practice and other locations run by the provider.
- There was an effective and thorough induction system for both permanent and temporary staff tailored to their role. Locum induction packs were clear, detailed and thorough.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis and reception staff had received guidance on sepsis awareness.
- Equipment and medicines were available for medical emergencies. At the last inspection in July 2017, we found an expired oxygen mask stored with their emergency equipment. During this inspection we saw that a full range of emergency medicines and equipment were available and appropriate and timely checks of these were being undertaken and recorded.
- The practice had a lone worker policy in place and a lone worker risk assessment had been undertaken. Following an instance where a staff member had been unable to get through to the practice during a home visits, the practice had implemented a direct phone line specifically for staff to contact the practice urgently.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. A comprehensive business continuity plan was in place.

**Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Management of correspondence in the practice was safe. The practice had clear systems to deal quickly with incoming information from other organisations including hospital letters and results.
- Referral letters included all of the necessary information and the practice monitored urgent referrals sent to ensure they had been received and actioned.
- At the previous inspection in July 2017 we found that systems for dealing with pathology results were not safe and there were no systems for monitoring patients who required colposcopy or where cervical screening samples were taken. During this inspection, we saw that the practice now had a failsafe system for ensuring results were recorded for every cervical screening procedure, inadequate results were audited and results from colposcopy were monitored.
- We also saw that the day to day system for managing pathology results was safe and acted on in a timely way; there were only five results not actioned which were all dated the day of our inspection.

**Safe and appropriate use of medicines**

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks and there was evidence this had improved since the last inspection in July 2017. Previously we found that there were no documented checks of vaccine stock expiry dates and we found an expired oxygen mask stored with their emergency equipment. During this inspection we found that there were clear systems for monitoring emergency medicines, emergency equipment and vaccines. The practice stocked a full range of emergency medicines and checks were carried out and recorded weekly.
- Management of prescription stationary had improved. At the last inspection we found that there were no systems in place to monitor prescriptions and uncollected prescriptions were not regularly being reviewed. During this inspection we found that prescription stationery securely stored and monitored and a policy was in place. The lead GP had also implemented an Uncollected Prescriptions Policy which

was being followed; uncollected prescriptions were reviewed monthly by a reception staff member and any uncollected scripts were checked by the lead GP to decide action to take. We found that there was no clear process to record when patients collected controlled drugs prescriptions; however was saw evidence that this was implemented immediately after the inspection, a policy put in place and the new system was shared with staff.

- Repeat prescribing systems in the practice were safe.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The practice were working with the local Clinical Commissioning Group (CCG) medicines team.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones for 2016/17 was 12% compared with a CCG average of 8.3% and a National average of 8.9%. Although broad spectrum antibiotic prescribing was higher than averages, up to date data from the patient record system demonstrated a reduction in the number of patients on broad spectrums in January 2018 compared with the data from November 2017.
- The practice had undertaken two full cycle antibiotic audits; prescribing to manage chest infections and prescribing of antibiotics for urinary tract infections. Both audits demonstrated improvements and the practice ensured up to date prescribing guidance was available in the 'live' locum induction pack which all staff had access to.
- There were effective protocols for verifying the identity of patients during the Hurley eConsult online consultation process.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. There was a system in place to ensure patients on high risk medicines were monitored.

**Track record on safety**

The practice demonstrated that improvements had been made in monitoring safety.

- There were comprehensive risk assessments in place in relation to safety issues, some of which were implemented immediately following this inspection, for example a more detailed health and safety risk assessment, a COSHH risk assessment and a blind cord loop risk assessment.
- The practice monitored and reviewed activity through a variety of meetings including practice operational meetings and management meetings. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- At the previous inspection in July 2017 we found that not all staff were aware of the practice's significant event process which limited the practice's ability to identify significant events and we found that learning from significant events was not embedded.
- During this inspection we saw that there was a safe system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The practice demonstrated that where there had been verbal complaints from patients about missed home visits by a locum GP, these had been written up and investigated as significant events. There was evidence that changes had been made to the patient record and appointment system so it was clearer for locum doctors how to allocate visits correctly. Guidance was also added to the online locum induction pack.
- Staff we spoke to described an incident where a staff member had been unable to get through to the practice urgently during a home visit as the phone lines were engaged. Following this, the practice had implemented a direct phone line specifically for staff to contact the practice for urgent concerns.
- The practice discussed significant events in the monthly practice meeting and clinically significant events in the weekly clinical meeting. An annual review of significant events was carried out.

Good

# Are services safe?

- The practice had recently commenced an annual training day for non-clinical staff in policies and procedures. This covered a number of topics including the significant event and complaint process to ensure staff were clear about their roles.
- There was a robust shared learning system across the provider organisation, so that learning from all the provider's serious incidents and complaints was shared with all staff via a quarterly newsletter produced by the clinical governance committee.
- There was a good system for receiving and acting on safety alerts. Clinical staff were able to recall recent alerts that had been discussed and acted on, for example a search had identified nine patients prescribed a specific inhaler that required a replacement due to a fault. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice and all of the population groups as good for providing effective services overall.**

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- The practice had an 'online' pack for all doctors which included links to up to date guidance, prescribing protocols and clinical pathways. This was especially beneficial for locum GPs.
- Up to date guidance was also disseminated via weekly clinical meetings and The Hurley Clinic Partnership Clinical Governance Committee newsletter which was produced quarterly
- From 15 medical records we viewed, patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. There was clear evidence of care plans being used to ensure a range of needs were identified.
- Clinicians were able to directly contact hospital specialists for best practice advice using an online system.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice held a contract to provide services to two Southwark care homes, which in total constituted 210 patients with complex needs. This represented 3.7% of the practice list size.
- From audits undertaken, the practice had identified a cohort of frail and vulnerable patients requiring a full assessment of their physical, mental and social needs including a review of medicines. Out of 20 patients identified, 17 (85%) had received a review so far in 2017/18.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The number of patients aged 65 and over who had received a flu immunisation for 2016/17 was 47%.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. There was a lead nurse in place for long-term conditions reviews.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Data from the Quality and Outcomes Framework (QOF) 2016/17 showed some achievements were below averages:
  - The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 62.7% compared with the Clinical Commissioning Group (CCG) average of 77.8% and the national average of 78.1%.
  - The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 68.6% (CCG 75.4%; national 79.5%).
  - In those patients with atrial fibrillation with a higher risk record, the percentage of patients who are currently treated with anticoagulation therapy was

Good

# Are services effective?

## (for example, treatment is effective)

87% (CCG 89.1%; national 88.4%). However those exception reported (not receiving treatment) was high at 25.8% compared with the CCG average of 8.6% and national average of 8.2%.
  - The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months was 74.9% (CCG 77.0%; national 76.4%).
  - The percentage of patients with COPD who had a review, including an assessment of breathlessness in the preceding 12 months was 92.2% (CCG 92%; national 90.4%), however those exception reported totalled 23.8% compared with a CCG average of 5.1% and national average of 11.4%.
- Evidence confirmed that the higher exception reporting rates and lower achievement scores for some of the QOF domains was due to a higher proportion of patients on the practice list (3.7%) with long-term conditions residing in care homes, where treatments or assessments were either contraindicated or not appropriate.
- The number of 'at risk' patients aged between 16 and 65 who had received a flu immunisation for 2017/18 was 68%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Data showed that uptake rates for the vaccines given were below the target percentage of 90% in all four areas for 2015/16, scoring an average of 88%.
- Unverified data for 2017/18 gathered during the inspection demonstrated that 81% of those aged 2 had been fully immunised.
- The practice had worked to improve uptake by sending the NHS 'new arrival' and '1 today' cards with the immunisation schedule detailed.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The number of pregnant women who had received a flu immunisation for 2016/17 was 28%.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 75%, which was in line with the CCG average of 75.6% and the national average of 80% for the national screening programme for 2016/17.
- The practice's uptake for breast cancer screening was 58.5% which was significantly below the national average of 70.3% for 2015/16.
- The practice's uptake for bowel cancer screening was 34.3% which was significantly below the national average of 54.6% for 2015/16.
- The practice was aware of the lower uptake of national cancer screening programmes which had been referenced in the previous report and had worked to improve this by running quarterly searches for eligible patients and sending letters and advice leaflets. However, there was no up to date data to demonstrate if this had improved.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including carers, homeless people, travellers and those with a learning disability.
- There were 23 patients on the learning disabilities register. 14 (61%) had received a health check so far in 2017/18.
- The practice had identified 67 patients acting as carers, which was 1.2% of the practice list. 52% of patients acting as carers had received a flu immunisation in 2016/17 and this increased to 57% in 2017/18.
- One of the GPs worked with a local detox rehabilitation unit to provide effective treatment.

People experiencing poor mental health (including people with dementia):

- Data from the Quality and Outcomes Framework (QOF) 2016/17 showed:

Good

# Are services effective?

## (for example, treatment is effective)

- 76.3% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is below the CCG average of 84.9% and national average of 83.7%.
- 92.6% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to CCG average of 93.2% and national average of 90.3%, however exceptions reported (patients not reviewed) was 23.6% which was above the CCG average of 7.4% and national average of 12.5%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 97.6% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is above the CCG average of 91.5% and national average of 90.7%.

- Evidence confirmed that the higher exception reporting rates and lower achievement scores for some of the QOF domains was due to a higher proportion of patients on the practice list (3.7%) with long-term conditions residing in care homes, where treatments or assessments were either contraindicated or not appropriate.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All clinical staff had received Mental Capacity Act training and all non-clinical staff had received training in dementia awareness.

**Monitoring care and treatment**

The most recent published Quality Outcome Framework (QOF) results were in line with averages at 94.6% of the total number of points available compared with the Clinical Commissioning Group (CCG) average of 95.3% and national average of 96.5%.

The overall exception reporting rate was 10.7% compared with a CCG average of 6.9% and a national average of 9.6%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) There was evidence the practice had worked to reduce the exception reporting rate compared with the previous year's exception reporting rate of 13%.

The practice had undertaken an exception reporting audit to review areas of high exception reporting for the 2016/17 QOF year. This confirmed that the higher exception reporting rates and lower achievement scores for some of the QOF domains was due to a higher proportion of patients on the practice list (3.7%) with long-term conditions residing in care homes, where treatments or assessments were either contraindicated or not appropriate.

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided through clinical and procedural audit.

- During the previous inspection we found that there were no systems for monitoring patients who require colposcopy or where cervical screening samples were taken. During this inspection, we saw that the practice now had a failsafe system for ensuring results were recorded for every cervical screening procedure, inadequate results were audited and results from colposcopy were monitored. This ensured there was an audit trail to monitor the safety and effectiveness of cervical screening.
- The practice used information about care and treatment to make improvements. A number of clinical audits had been carried out in the last two years. We were shown four completed audits. For example, the practice undertook an audit in the prescribing of anticoagulants and whether a stroke and bleeding risk assessment had been completed. The two cycle audit demonstrated that there was a significant increase in the number of patients who had a risk assessment carried out, which improved the monitoring of a number of patients with complex conditions who resided in care homes.
- The practice conducted medicines audits, including two completed antibiotic audits, both of which resulted in improved prescribing in line with local guidance.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles.

Good

# Are services effective?

## (for example, treatment is effective)

- Staff undertook role specific training, such as clinical update courses. Nurses had received specialist training in diabetes, asthma, immunisations and taking samples for the cervical screening programme.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop.
- Records of skills, qualifications and training were well-monitored and maintained.
- The practice had implemented an annual 'policies and procedures' training for non-clinical staff since the previous inspection in July 2017, to improve understanding of practice systems. This had been well-received by staff.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. All staff had received an appraisal in the last year or had an appraisal booked.
- There was evidence of cross-site working, such as appraisals for GP staff.
- The induction process provided to locum GP staff was comprehensive and included a 'live' induction pack with links to guidance, policies and procedures.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

**Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- The practice's systems for managing referrals, results and correspondence were safe.
- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The practice followed up frequent Accident and Emergency attenders, unplanned admissions and where children failed to attend hospital appointments.
- The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- Clinical meetings took place weekly and all clinical staff including the nurse and health care assistant were invited to attend. Multidisciplinary meetings with district nurses and the palliative care team occurred monthly.

**Helping patients to live healthier lives**

Staff reported they were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition, patients with a learning disability and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Patients were invited for the NHS heath check; 57% had attended for a review so far in 2017/18.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. Administrative staff were involved in identifying smokers and sending out information about smoking cessation and support services.
- The practice was aware of the lower uptake of national cancer screening programmes which had been referenced in the previous report and had worked to improve this by running quarterly searches for eligible patients and sending letters and advice leaflets.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway 2016/17 was 36.8% which was lower than the Clinical Commissioning Group (CCG) average of 53.4% and national average 51.6%. The practice reported this was due to the higher proportion of care home residents that were registered.

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

Good

# Are services effective?

## (for example, treatment is effective)

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- All clinicians had received training in mental capacity and non-clinical staff had undertaken dementia awareness training.
- The practice monitored the process for seeking consent appropriately.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We observed staff to be caring and helpful.
- We spoke with 10 patients and comments about the care experienced were very positive. Patients felt that services had recently improved and patients had noted these improvements since the practice had a more stable number of permanent GPs. Patients also commented on the kind and empathetic manner of reception staff.
- We received 25 patient Care Quality Commission comment cards, and all but one were highly positive about the level of care experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect, although in general the results were lower than the previous year's patient satisfaction data. There were 386 surveys sent out and 91 were returned. This represented about 1.6% of the practice population. The practice was in line or below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 79.3% of patients who responded said the GP was good at listening to them compared with the Clinical Commissioning Group (CCG) average of 86% and the national average of 89%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 96%.
- 76% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 83%; national average – 86%.
- 85% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 86%; national average - 91%.
- 85% of patients who responded said the nurse was good at listening to them; CCG - 85%; national average - 91%.

The practice reported that the last national GP patient survey data related to a period when the practice had a less stable clinical staffing structure so may not be reflective of current satisfaction.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets could be made available in easy read format if required.
- Staff communicated with patients in a way that they could understand; for example, communication aids were available, such as a hearing loop.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by their doctor or nurse and had sufficient time during consultations.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers via advertising in the waiting area and asking patients at registration. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 67 patients as carers (1.2% of the practice list).

- Information about local carers support services were available in the waiting area.

Good

# Are services caring?

- The Patient Participation Group (PPG) had assisted in running practice coffee mornings where patients and carers were able to attend.
- The practice had offered flu immunisations to carers.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients did not always respond positively to questions about their involvement in planning and making decisions about their care and treatment. Results were below or in line with local and national averages:

- 67% say the last GP they saw or spoke to was good at involving them in decisions about their care compared with the Clinical Commissioning Group (CCG) average of 77% and national average of 82%.
- 72% say the last GP they saw or spoke to was good at explaining tests and treatments; CCG - 83%; national average - 86%.
- 79% say the last nurse they saw or spoke to was good at involving them in decisions about their care; CCG - 80%; national average - 85%.
- 85% say the last nurse they saw or spoke to was good at explaining tests and treatments; CCG - 85%; national average - 90%.

The results from the patient survey did not align with patient comments on the inspection day. Patients were very positive about involvement in decisions about their care, particularly for babies and young children. The practice reported that the last national GP patient survey data related to a period when the practice had a less stable clinical staffing structure so may not be reflective of current satisfaction.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could not be overheard by patients in the waiting room.
- Patients could be offered a private room to discuss their needs.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as good for providing responsive services.**

**Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- The practice improved services where possible in response to unmet needs, for example they instigated a 'one stop shop' mother and baby clinic weekly with the health visitor and nurse to manage mother health check and baby immunisation needs during one visit.
- The practice had appointed a pharmacist as part of a local clinical pharmacist initiative to commence in March 2018 to improve timely medicines reviews and to assist with management of long term conditions.
- The provider held a contract to provide services to two Southwark care homes and a GP with a special interest in substance misuse provided services to a local detox rehabilitation facility.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The facilities and premises were appropriate for the services delivered; all treatment and consultation rooms were on the ground floor.
- The practice made reasonable adjustments when patients found it hard to access services. For example, a hearing loop was installed. During the inspection we found there was no emergency call facility in the disabled access toilet. An emergency call system was implemented immediately after the inspection.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice provided services from two regular doctors to 210 patients living in care homes.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.
- There was a medicines delivery service for housebound patients.
- The practice hosted coffee mornings which were targeted at all patients but specifically older and vulnerable patients and their carers.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Phlebotomy services were available in-house.
- The practice were able to refer patients to a range of lifestyle improvement services including the in-house dietician, local exercise referral schemes and in-house smoking cessation.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- There was evidence that the practice followed up children who had not attended for immunisations.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice offered a weekly one-stop clinic with the nurse and health visitor to enable health checks and immunisations to be carried out in one visit. Patients we spoke to were happy with this service.

Working age people (including those recently retired and students):

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- The needs of this population group 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, extended opening hours three mornings per week.
- Patients were able to use the Hurley Clinic Partnership eConsult system to ensure timely access to advice and treatment within 48 hours.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Campaign-based Saturday clinics were scheduled over the year.
- The practice offered NHS health checks and case finding checks on patients of any age with high risk factors for developing Diabetes or Cardiovascular disease.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including carers, homeless people, travellers and those with a learning disability.
- The practice was located in a more deprived area; information was available to direct patients in need of support for example, those affected by domestic abuse, female genital mutilation and substance misuse.
- Additionally the practice participated in providing vouchers for the local food bank to ensure access and advice for those most in need.
- The practice provided GP services at a local substance misuse rehabilitation facility.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice discussed patients with mental health needs during weekly clinical meetings.
- Patients received mental health and dementia reviews. Patients who failed to attend were proactively followed up by a phone call from a GP.

**Timely access to care and treatment**

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Routine appointments could be booked up to four weeks ahead for GP consultations and six weeks ahead for nurse consultations. The next available routine appointment was within two weeks.
- Urgent appointments were available via telephone triage on the day with a duty GP and they were given face to face appointments if required.
- Patients felt they were easily able to contact the practice by telephone.
- The appointment system was easy to use and most patients felt they were able to get appointment when they needed it; however some patients reported they could wait up to three weeks for a routine appointment and two patients reported a delay waiting for the duty clinician to call them back following a request for an urgent appointment.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and feedback from patients in the 25 completed CQC comment cards. We saw that 386 surveys were sent out and 91 were returned. This represented about 1.6% of the practice population. Results showed:

- 79% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 80%.
- 90% of patients who responded said they could get through easily to the practice by phone; CCG - 75%; national average - 71%.
- 67% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 73%; national average - 76%.
- 78% of patients who responded described their experience of making an appointment as good; CCG - 70%; national average -73%.
- 69% would recommend this surgery to someone new to the area; CCG - 76%; national average 79%.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them appropriately. Lessons were learnt and changes were made in the practice from complaints.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.
- The practice recorded verbal and formal concerns and complaints.
- Information about how to make a complaint or raise concerns was available in the waiting area and online. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Six complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, following a complaint about the approach of locum GP, the practice improved the guidance pack available to all doctors with up to date links to local referral systems and services.

# Are services well-led?

Good

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

## Our findings

**We rated the practice and all of the population groups as good for providing a well-led service.**

**Leadership capacity and capability**

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Since the previous inspection in July 2017, the practice had benefited from a more stable leadership team. The lead GP had been appointed who provided clinical leadership and the new regional manager supported the practice manager and provided managerial leadership.
- Both leaders in conjunction with the practice manager and the Hurley Clinic Partnership executive management team had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- Leaders and managers were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. We found the practice had addressed areas of improvement identified at the previous inspection in relation to the safe management of medicines and equipment, infection control and governance processes. Where challenges remained in respect of the premises, there was evidence leaders were addressing this.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

The practice had a clear vision to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The majority of the objectives focussed on improving the premises to enable expansion of the practice and equitable access.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice's objectives were in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population in conjunction with the Clinical Commissioning Group (CCG).

**Culture**

The practice had a culture of high-quality sustainable care.

- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, there were four verbal complaints where home visits had been missed due to an error by a locum GP. The practice had investigated these as significant incidents and contacted patients and/or their carers involved. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were positive relationships between staff and teams. Staff felt that a better support structure was in place since the last inspection and they felt there was a more stable clinical team.
- The practice held team meetings for all staff monthly. The reception team met every two weeks and clinical meetings occurred weekly.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. The practice nurse and health care assistant attended a local practice nurses' forum monthly.
- There was an emphasis on the safety and well-being of all staff.

# Are services well-led?

Good

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

- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- Leaders and managers challenged behaviour and performance inconsistent with the vision and values.

**Governance arrangements**

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- At the previous inspection in July 2017 we found that governance arrangements were not in place for processes related to significant event management, medicines management, infection control, safeguarding and complaints.
- At this inspection there was evidence that governance arrangements had improved. Communication flow between management, non-clinical and clinical staff had been refined. In particular there were systems in place to ensure governance arrangements were communicated to locum staff via a 'live' induction pack with updated links to relevant guidance and policies.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Training for non-clinical staff had been implemented to refresh their knowledge in the most important practice policies and procedures such as significant events and complaints. This had commenced in January 2018 and staff found this had been effective in giving them information to carry out their roles.
- The practice had a thorough process for monitoring mandatory training for staff.
- Structures, processes and systems to support good governance and management were underpinned by a clear meeting structure. Quarterly Clinical Governance Committee meetings resulted in a quarterly newsletter to all practice locations, detailing learning from complaints and significant events across the provider locations, patient safety and medicines alerts and evidence based guidance. In addition clinical meetings occurred weekly. Clinical governance was also provided by the Hurley Clinic Partnership medical director 'on-call' so that back up was provided in the event that the lead GP was unavailable.
- The practice reviewed complaints and significant events annually. These were also discussed at clinical meetings and at the all staff meeting monthly.
- Practice operational meetings occurred monthly between the lead GP and managers.

**Managing risks, issues and performance**

There were improved processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. Shortly after the inspection, a detailed health and safety risk assessment was carried out which showed a co-ordinated approach to risk as it linked risks related to infection control, health and safety, fire safety and the control of substances hazardous to health.
- The Hurley Clinic Partnership business manager had involvement in the ongoing monitoring of health and safety of the premises.
- The practice had thorough training for all staff at induction and on an ongoing basis to ensure risks were managed and mitigated.
- The practice had business continuity plans in place and had trained staff for major incidents.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Practice leaders had oversight of national and local safety alerts, incidents, complaints and performance data for the service.
- Clinical audit and procedural audit had a positive impact on quality of care and outcomes for patients. There was evidence of a number of clinical audits that had improved quality in the practice.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

**Appropriate and accurate information**

# Are services well-led?

Good

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

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. For example, online consultations were available for patients and doctors used an online consultation system to seek best practice advice from consultants.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

The practice had some systems to involve patients, the public, staff and external partners to improve the service delivered.

- There was evidence that some patients', staff and external partners' views and concerns were acted on to shape services. The Patient Participation Group (PPG) reported that over the last two years they had been instrumental in providing a disabled parking space, improving outside areas and suggesting a 'who's who' staff photograph board in the waiting area. They were also involved in running coffee mornings.
- The PPG consisted of 5 regular members who met quarterly. There was limited evidence from these meetings that the group had an impact on improving the service delivered. The practice reported they had difficulty recruiting members despite advertising in different ways and changing times of the PPG meetings to Saturdays so that more patients could attend.
- The practice had held an engagement event open to all patients in November 2017 to keep patients abreast of developments related to relocation of the practice and current premises issues.
- NHS Friends and Family Test (FFT) results showed that on average 78% would recommend the practice. There was a downward trend that showed 87% would recommend the practice in August 2017 and 71% would recommend the practice in February 2018.
- The practice sent a survey quarterly to 50 patients regarding satisfaction with treatment and appointments. Results from the last two surveys (September 2017 and December 2017) showed that on average 81% of patients would recommend the practice.

**Continuous improvement and innovation**

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. Significant events and complaints were shared with all staff during practice meetings and learning from the provider's other locations' significant events and complaints was circulated via the quarterly clinical governance newsletter.
- The practice provided a new 'live' induction pack for all GPs including locums which provided online links to key guidance and practice procedures to enable safer working practices.
- The practice had implemented a new policies and procedures training programme for non-clinical staff so they were clear about their roles and responsibilities. This had improved governance in the practice and was welcomed by staff.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.