Battersea Rise Group Practice

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?	Requires improvement
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

We carried out an announced comprehensive inspection at the Battersea Rise Group Practice on 04 March 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the six population groups we report on.

It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider must:

- Improve the storage arrangements for vaccines and other medicines so that they are secure and correctly monitored in line with national guidance.
- Improve the fire safety arrangements including the provision of staff training and the use of alarm tests and drills.

Summary of findings

- Put in place the correct and up-to-date legal authorisations required for staff to carry out their roles safely.

In addition the provider should:

- Carry out a risk assessment in relation to legionella.
- Set out a schedule for testing, or a protocol for maintaining, the safety of portable electrical appliances.
- Review staff compliance with the storage protocols for some higher risk documents including prescription pads.
- Review and update the business continuity plan and share these updates with staff to ensure that there is a current protocol in place for dealing with emergencies.
- Improve the recording of staff meeting minutes and share these with all staff, including locum GPs, to improve communication and the sharing of best practice decisions with all staff.
- Provide patients with care plans in place with a copy of these plans for reference purposes.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

Some medicines were not stored securely and could potentially have been accessed inappropriately by members of the public. Vaccine storage did not follow current guidelines as we identified issues with the monitoring of the temperature at which these were stored.

Fire safety had been assessed but recommendations to reduce risk had not been implemented. Legionella risk had not been assessed.

The legal authorisation required by the health care assistant to carry out flu vaccinations had not been completed correctly and was out of date.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' 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 some training appropriate to their roles and a discussion of further training needs had taken place during annual appraisals. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect, and that they were involved in decisions about their care and treatment. Patients understood the information given to them by their GP, were confident about discussing their concerns and were listened to well. Staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

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 local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients generally reported they had good access to the GP and could get an appointment when they needed to. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. There was evidence which showed that the practice responded quickly to any issues raised and implemented changes to their systems to prevent problems from occurring again.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood this vision and their responsibilities as regards to working towards maintaining high standards of care for patients. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and had been regularly consulted about the future of the practice with a view to driving improvements. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. Older patients had a named GP and were offered home visits and rapid access appointments. The practice worked to ensure that older patients were seen by a clinician on a regular basis with contact made a minimum of every six months.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with long-term conditions had care plans in place that were drawn up under a local arrangement called 'Planning All Care Together'. Patients are given additional time with their GP to discuss their needs and concerns. A care plan is then drawn up in conjunction with other relevant health care providers and with good patient involvement. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Patients we spoke with who were living with long-term conditions told us they had good access and relationships with the GPs. They felt well-cared for by the GPs and nursing staff.

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. Regular meetings were held with other health care professionals, including health visitors and midwives, to discuss any ongoing concerns.

The practice had a relatively larger population of families with young children. Children were prioritised for same day appointments and telephone consultations. New mothers were offered an extended appointment eight weeks after giving birth and were offered referral to a local parenting course. The practice promoted a breast-feeding friendly policy and had a child-friendly area in the waiting area with toys and books.

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

Summary of findings

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. The practice offered appointments outside of normal working hours on five days of the week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There was a register of patients living in vulnerable circumstances including those with a learning disability. Vulnerable people were offered an annual health check and referred on to other services appropriately. There were alerts on an electronic system to remind staff to give vulnerable people fast-track appointments with the clinicians. The practice encouraged vulnerable patients to access various support groups and voluntary organisations.

The practice had a lead GP who was responsible for safeguarding vulnerable adults and children. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had systems in place to identify people who may be at risk of experiencing poor mental health. For example, carers were encouraged to identify themselves and were offered additional support. People with mental health needs were offered an annual physical health check and care plans were in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Two psychologists held sessions at the practice each week to support people experiencing mental health issues.

Summary of findings

What people who use the service say

Twenty-seven people completed comment cards telling us about their experience of using the service. We also spoke with two people who were registered with the practice during our inspection. The majority of feedback from patients was complimentary about the level of care they received from clinicians and their interactions with administrative staff.

The national GP patient survey results found that the practice was performing well. The majority of people reported that their GP treated them with care and concern. The practice had also carried out its own practice survey to identify areas where they could improve. This survey also found that patients' were reporting high levels of satisfaction with the service.

Most people found the appointments system easy to use and could get an appointment when they needed one.

Appointments could be made in advance or people could arrange to see a clinician on the same day if they had an urgent need to do so. People with long-term conditions, or families with young children, knew they could get priority access to see a GP if they had any concerns.

People told us their GPs were good at including them in making decisions about their care and treatment. They generally understood the explanations given to them, and felt confident about asking questions about their care.

Patients described good systems for obtaining repeat prescriptions and referrals to other services. People who needed to be seen for regular reviews told us they were prompted by administrative staff to make an appointment in good time.

Areas for improvement

Action the service MUST take to improve

- Store medicines securely and in such a way as to ensure that they cannot be accessed by members of the public.
- Store vaccines in line with national guidance and improve the monitoring of vaccine storage to identify any risks.
- Carry out regular fire alarm tests and drills, and provide staff with relevant fire safety training.
- Review the arrangements for making Patient Group Directions and Patient Specific Directions to ensure they meet with the legal requirements.

Action the service SHOULD take to improve

- Carry out an assessment for legionella risk.
- Set out a schedule for testing, or a protocol for maintaining, the safety of portable electrical appliances.
- Review arrangements for the secure storage of prescription pads.
- Update the business continuity plan and share this information with all members of staff.
- Share staff meeting minutes with all members of staff, including locum staff, to ensure the effective sharing of information and updates.
- Provide patients with care plans in place with a copy of these plans for reference purposes.

Battersea Rise Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a Lead CQC Inspector, a second CQC inspector and a GP specialist advisor who was granted the same authority to enter the practice premises as the CQC inspectors.

Background to Battersea Rise Group Practice

The Battersea Rise Group Practice is located in the London Borough of Wandsworth. The practice serves approximately 7,300 people living in the local area. The practice operates from a single site. It is situated in a four-storey building in a high street location.

There are two female GP partners working at the practice. There are also three salaried GPs (one of whom is male), and two locum GPs providing regular sessions. There are two practice nurses and a health care assistant. The practice hosts sessions for two visiting psychologists through the Improving Access to Psychological Therapies (IAPT) service. It also offers a diabetes clinic, an anticoagulant clinic, phlebotomy, spirometry, methotrexate monitoring and post-natal and family planning clinics, including fitting of intrauterine devices (IUD).

The practice offers appointments on the same day and takes bookings up to three weeks in advance. The practice provides appointments between 8:00am and 6:30pm on Mondays to Fridays. They offer extended opening hours on Mondays to Thursdays between 7.30am and 8.00am and between 6:30pm and 8:30pm, and on Saturday mornings between 8:30am and 11:00am. At other times, patients are advised to call the NHS '111' service for advice and onward referral to an out-of-hours GP service, as necessary.

The practice has a relatively large population of registered families with young children. The practice supports the needs of breast-feeding mothers by promoting a breast-feeding friendly policy in the waiting area and offers a more secluded area, on request, for breast feeding.

The Battersea Rise Group Practice is contracted by NHS England to provide General Medical Services (GMS). They are registered with the Care Quality Commission (CQC) to carry out the following regulated activities: Surgical procedures; Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Treatment of disease, disorder or injury. Although the practice is registered to carry out surgical procedures, this is limited to joint injections. Other minor surgery is carried out via referral to secondary care services, such as those provided by a local NHS Foundation Trust.

Why we carried out this inspection

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

Detailed findings

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.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 04 March 2015. During our visit we spoke with a range of staff. We spoke with four GPs, a practice nurse, a health care assistant, a practice manager and two reception staff. We spoke with two patients who used the service and reviewed twenty-seven comment cards where patients shared their views about the service. We observed patient and staff interactions in the waiting area. We conducted a tour of the surgery and looked at the storage of medicines and equipment. We reviewed relevant documents produced by the practice which related to patient safety and quality monitoring. We reviewed some patients' care plans and associated notes.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice could demonstrate they had a good track record for maintaining patient safety. They used a range of information sources to identify risks and improve safety. For example, the practice identified and investigated serious incidents, monitored national patient safety alerts and reviewed comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

All of the serious adverse events and patient complaints were reviewed at designated staff meetings to identify any common themes and monitor the effectiveness of changes that had been implemented to the service. We saw that the most recent discussion of these had taken place in January 2015.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. All staff were aware of the systems for reporting incidents and how to escalate these for the attention of the practice manager or GP partners.

National patient safety alerts were disseminated by the practice nurse and one of the GP partners at staff meetings and via electronic messaging systems. We saw examples of alerts which had been circulated, such as a scarlet fever alert in January 2015.

There had been three recorded serious adverse events in the past year. In each case the practice carried out an investigation and implemented strategies to prevent any problems from occurring again. For example, in one case a blood test result had not been seen by the requesting clinician in a timely manner. The practice identified that the result had not been picked up through usual channels including an expected call from the laboratory which had carried out the test, or a call from the patient to pick up their results. Therefore, the practice implemented additional safety-netting strategies including requiring the doctor on duty for each session to review all of the results received that day to ensure they were acted on.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role-specific training on safeguarding. Clinical staff had completed Level three training in child protection and administrative staff had completed Level one training. Clinical and non-clinical staff had also attended a safeguarding awareness day organised by their clinical commissioning group to discuss the protection of vulnerable adults.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns, and how to contact the relevant agencies in working hours and out of normal hours. Contact details for local safeguarding agencies were easily accessible and visible in the reception area.

One of the GP partners was the lead for safeguarding vulnerable adults and children at the practice. We discussed the systems in place to protect vulnerable patients with this GP. They showed us there were alerts attached to patients' electronic records if the practice had identified that they might be at risk for any reason. Therefore clinicians could be reminded to look out for any signs of neglect or abuse when these patients attended the practice. The GP safeguarding lead also told us that they liaised with the relevant authorities in relation to safeguarding alerts and case conferences by providing timely information. They attended quarterly meetings for local safeguarding leads at a local NHS Foundation Trust in order to keep up to date and share relevant guidance. Patient-specific issues were discussed at multi-disciplinary team meetings. For example, some child protection issues were discussed at weekly meetings with a health visitor.

There was a chaperone policy, and this service was advertised on a noticeboard in the waiting area, although not displayed in the consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Reception and nursing staff were available to act as chaperones. Staff who acted as chaperones had had relevant background checks through the Disclosure

and Barring Service (DBS). Staff had not received formal training in chaperoning, but the practice manager and GP partners told us they had discussed the form and content of chaperoning duties with relevant staff.

Medicines management

The practice must improve the way they manage medicines.

We checked the way medicines were stored in treatment rooms and refrigerators. There were two refrigerators for storing medicines including vaccines. The practice nurse was responsible for checking the temperature of these on the days that she worked at the practice (Tuesday to Thursday). We saw that the nurse had checked the temperatures on these days. There were no systems in place to check the temperature of refrigerators on Mondays and Fridays.

The refrigerator in the nurse's room displayed minimum and maximum temperatures recorded during the day. These should have been between two and eight degrees Celsius. We saw that the refrigerator had showed a maximum temperature of 12 degrees, which exceeds the maximum recommended range. We noted that the nurse's record showed that this maximum temperature had been recorded throughout the preceding three months and the nurse had not raised this as a concern with other clinicians. We investigated this issue further and discovered that the nurse had not used the 'reset' button on the refrigerator after checking the minimum and maximum temperature. Therefore it was not possible to say on which days the refrigerator had exceeded the maximum temperature as it was only showing the record from the first day the temperature was out of range.

A second temperature probe, which is independent of mains power, is recommended for use inside refrigerators in Public Health England's Protocol for Ordering, Storing and Handling Vaccines (issued March 2014), which in this case would have been useful for resolving this issue. The practice was not using a second temperature probe in its vaccine fridges.

We asked the GP partners and practice manager to investigate these risks. They reported to us that they had contacted Public Health England (PHE) to report the issue and carried out a significant event analysis. They had contacted the vaccine suppliers for all vaccines that could have been stored in the fridges during the period their temperatures were recorded as out of range. They told us the manufacturers confirmed that the vaccines were still safe and effective to use at the out of recommended range temperatures they had recorded, and higher. Therefore they felt there were no risks to patients. However, the Protocol clearly states that any vaccine that has not been stored at between two and eight degrees, as per its licensing conditions, is no longer a licensed product. The practice cannot be confident that their storage arrangements have kept vaccines within the required temperature range.

We sought advice from specialist pharmacy advisors at the Care Quality Commission (CQC) about this issue. Medicines stored outside of their correct storage conditions are no longer a licensed product and must be described as such to parents and people receiving them. A leaflet has been produced by PHE (November 2014) for this purpose. This leaflet is called: "The use of vaccines that have been temporarily stored outside the recommended temperature range: A brief guide for parents."

Some medicines were stored in an unused consulting room. Medicines in this room were checked weekly to ensure they were within their expiry dates. Emergency medicines were stored in a locked medicines cabinet in this room. The key to the cabinet was left on top of the cabinet. Other (non-emergency) medicines were stored on shelves in the consulting room. This included some anti-psychotic medicines. The consulting room door was unlocked. Therefore members of the public could potentially have inappropriately accessed these medicines as they moved between the waiting area and other consulting rooms.

The health care assistant (HCA) was administering flu vaccines. In order to be able to do this, it is a legal requirement that a clinician provides the HCA appropriate authorisation through a Patient Specific Direction (PSD). We found that the PSD in place for the HCA to administer flu vaccines had not been authorised by a clinician, but had instead been signed by the practice manager. The PSD was also out of date (expired in September 2013). There should be a PSD in place for each individual with a record for each individual signed by both a clinician and the HCA.

The practice also had a number of Patient Group Directions (PGDs) in place providing authorisation for the nurses to provide a range of general health and travel health

vaccinations for specific groups of patients. We reviewed a number of these and found them to be in date, and subject to regular reviews. However the PGDs were also not authorised by a clinician.

All prescriptions were reviewed and signed by a GP before they were given to the patient. However, blank prescription forms were left in unlocked drawers and in printers in consulting rooms that were not in use. These consulting rooms were not consistently locked and therefore prescriptions were not kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. The feedback we had from patients was that the practice was clean and they did not have any concerns about cleanliness or infection control. Cleaners worked regularly at the premises.

The practice nurse was the lead for infection control. We reviewed a document confirming they were due to attend a further training course on this topic at the end of March 2015. The nurse had carried out an infection control audit in January 2015 and identified actions which would improve infection control. This included updating training for other members of staff. The nurse also cited examples of how she disseminated good practice guidance on infection control. For example, she had recently distributed copies of a hand hygiene quality audit and discussed this with staff at a meeting.

Clinical and administrative staff were able to describe measures that were in place to control infection. They had good access to personal protective equipment including disposable gloves and aprons. Staff described instances when they used this equipment. For example, reception staff told us they used protective gloves when handling samples delivered by patients to the practice. We also saw that notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in consulting rooms.

The practice had not carried out a legionella risk assessment and was not carrying out regular checks of the water system for signs of legionella (a bacterium found in contaminated water which can be potentially fatal).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. The healthcare assistant had the responsibility for ensuring there was adequate supply of key items of equipment in the consultation and treatment rooms. She also ordered additional items when stocks ran low. She described how and when she carried out these duties, and said she knew what items to check in each room from experience. We noted she was not using any form of checklist to carry out these checks so there was a risk of stock items being missed that needed to be replenished.

We saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place and we saw that a number of items had been checked in September 2014. The practice manager was aware of when equipment needed to be tested again and organised for these tests to take place in good time. For example, the practice manager was aware that the spirometer would need testing again at the end of March 2015. However, portable electrical equipment was not routinely tested to ensure they were safe to use. The last time these appliances had been check was in February 2013 and a date had not been set to check these items again.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

There were suitable 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 enough staff were on duty. 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.

Requires improvement

Are services safe?

There were two locum GPs providing one session each at the practice at the time of our inspection. We noted that the practice was actively recruiting a new, salaried GP to reduce their reliance on locum sessions and to consistently cover their extended-hours surgeries.

Monitoring safety and responding to risk

The practice had some systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. For example, there was a health and safety policy which identified who was responsible for managing a range of issues including the prevention of accidents and the maintenance of healthy working conditions.

Steps had been taken to maintain the security and confidentiality of patients' records. Staff had received training in information governance. There was a security-locked door between the waiting area and the consulting rooms. There were swing doors separating the reception desk from the staff's computer work stations and patients' paper records, ensuring that reception staff's work could not be seen, and telephone calls in the administrative office could not be overheard by members of the public.

Fire safety equipment was checked annually. A fire risk assessment had been carried out by an external company in December 2014. A number of recommendations had been made in this report. These included the provision of staff training in fire safety, the carrying out of weekly fire alarm tests and the use of regular fire drills to familiarise staff with emergency procedures. None of these actions had yet been implemented. We discussed these issues with the practice manager and one of the GP partners. They took action to book some key members of staff on a fire safety course and committed to carrying out fire alarm tests and drills.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. All staff received training in basic life support. Emergency medicines and equipment, such as an oxygen cylinder, were available and these were checked regularly. Emergency equipment was all stored in a room on the ground floor and all staff were aware of their location.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. A copy of this plan was visible and available for all staff in the reception area. The plan included contact details for key suppliers. However, we noted that some contact details for utility services and computer systems were either not up to date or had not been included.

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. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice disseminated this information at practice meetings. However minutes were not always recorded and distributed to the staff team. We noted that the locum GPs who were providing regular, weekly sessions did not attend these meetings and thus did not benefit from the sharing of this information.

We found from our discussions with all of the GPs and nursing staff that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice had offered extended appointments to patients with long-term conditions and learning disabilities to discuss their care needs.

The GPs took the lead in different specialist areas such as diabetes, chronic obstructive pulmonary disease (COPD), and sexual health. The practice nurse supported this work and had also been trained in diabetes care. The practice offered a range of dedicated clinics including clinics for patients diagnosed with diabetes and for those using warfarin or other anticoagulants who needed to have regular blood tests. The clinical staff we spoke with told us they knew who was the lead in each area and could ask their colleagues for advice or support in relation to assessing and managing patients with these conditions.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All the GPs we spoke with used national standards for referral, such as urgent referrals for patients with suspected cancer so that they would be seen by an appropriate consultant within two weeks. The practice was using a scheme whereby the GPs could email a secondary care consultant with queries about any patients and receive a reply within 48 hours. The GPs reviewed the responses from this system in order to share advice and identify good practice in terms of referrals.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and GPs to support the practice to carry out clinical audits.

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. We saw examples of minutes from staff meetings and of clinical peer review sessions. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

The practice had carried out a range of clinical audits in recent years and could demonstrate how these audits had been used to improve outcomes for patients. For example the practice had completed two cycles of an audit examining the numbers of intrauterine devices (IUD) fitted for contraceptive purposes and the numbers of women who had returned for a six-week check following insertion. The initial audit in 2013 had found that low numbers of women (40%) were returning for their six-week check. A target had been set to improve this figure to 80% in 2014. The second audit in 2014 demonstrated that this target had been met through the provision of further information and improved access to advance appointments.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by their GP. We were also shown evidence that the practice was involved in the local clinical commissioning group (CCG) prescribing incentive scheme to encourage high quality and cost-effective prescribing. The practice had committed to carrying out various prescribing reviews in the coming year, including a review of the use of pain relief medicines. The practice could show us examples of previous prescribing reviews they had carried out to in response to new medicines management information or safety alerts. For example, a review of patients using

Good

Are services effective?

(for example, treatment is effective)

glucosamine had been carried out in March 2014 in response to information showing that it was not recommended for NHS prescribing due to a lack of evidence of effectiveness. All patients using glucosamine had been identified and successfully moved off this medicine, in line with new guidance.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The GP partners used data comparing their performance against other practices in the local area to identify areas where they could improve. The practice was performing well in some areas. For example, they had no outliers in terms of the rates of prescribing for different medicines. They could also show that the number of people registered at the practice attending the local hospitals' accident and emergency departments was low compared to other practices. The practice had recognised areas where they could improve. For example, data comparing their number of identified patients with COPD against the expected number for their practice population showed that they might not have identified all of the patients experiencing this illness. The practice planned to invite patients who were smokers and over the age of 40 years to attend for a screening session which would include the use of spirometry.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For the year 2013/2014 the practice had achieved 93.5% of all QOF targets which compared favourably with the CCG average of 92.4%. We explored how much progress the practice had made in relation to QOF targets for the current year (2014/2015). The practice continued to perform well in some areas. For example, 84% of eligible patients had attended for a cervical smear test in the last five years which was above the target set of 80%. The GP partners were aware of the areas where the performance could still be improved before the end of year, for example, in relation to smoking advice and uptake of annual reviews for patients with some long-term conditions or learning disabilities.

The practice had achieved and implemented the gold standards framework for end-of-life care and they maintained a palliative care register. Regular internal and multidisciplinary meetings were held to discuss the care and support needs of patients on the register. The practice developed 'Continuing Care Records' with patients which could then be shared with community specialist care nursing, London Ambulance Service and Out of Hours services to ensure timely and high quality care. Patients who had had a cancer diagnosed within the last five years were invited to attend for a holistic cancer care review to monitor their health and offer additional support.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff.

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support and safeguarding children.

We noted a good skill mix among the doctors and nurses. For example different doctors held diplomas in diabetes, COPD, asthma care, and sexual health. The practice nurses also had defined duties and specialisms. This allowed the practice to focus on specific conditions. They were able to demonstrate that they were trained to fulfil these duties. For example, a nurse had completed training in a range of topics, such as childhood immunisations within the past year and was due to complete an infection control course in March 2015 so that she could meet patient needs effectively.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. There was a clear management structure which encompassed details of who was responsible for line managing each member of staff including the carrying out their appraisal. We reviewed notes from staff appraisals and saw that standards of performance had been discussed as well as any training needs for the coming year.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice manager and one of the GP partners showed us the systems in place for monitoring and responding to communications from other providers as they were received. These had been largely effective and ensured that information was acted on promptly.

There had been one instance in the past year where a test result had not been acted on in a timely manner by a GP. The practice had investigated this incident and taken appropriate steps to prevent the problem from recurring. A range of actions had been implemented. For example, the responsibility for checking all results had been assigned to a duty doctor for each session who now checked the results for the previous day and acted on any significant results identified.

The practice held internal clinical meetings on a weekly basis. The agenda for each meeting was set and displayed in the meeting room. We observed that the agenda and minutes for these meetings regularly included reviewing complex patients, for example, those with end-of-life care needs. The GP partners told us they also attended multi-disciplinary meetings with other providers. We saw some samples of minutes from these meetings. For example, we saw that a meeting had been held to review people receiving end-of-life care in October 2014. Representatives from the practice, local hospice and a district nurse all attended this meeting in order to review patients' care needs.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. Staff were trained to use the system and paper communications, such as those from the hospital, could be scanned and saved onto the system for future reference.

The practice had systems in place to communicate efficiently with other providers and worked to ensure they were using the most up-to-date electronic systems available for this purpose. The practice manager showed us evidence of a new system being put in place to enable the efficient sharing of information with providers across the CCG area. They were part of a pilot scheme in the area trialling new computer software which incorporated pro formas for the recording of accurate referral information.

The practice was involved in an initiative which was designed to improve patient needs assessment with a view to delivering high quality care. The practice was engaged in Wandsworth CCG's 'Planning All Care Together' (PACT) programme to improve the co-ordination of care for patients with long-term conditions. Care plans had been developed which could, with the consent of patients, be shared with other health care professionals. GPs at the practice attended bi-annual meetings at the CCG to review the success of this approach.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).The principles of the Mental Capacity Act had been shared with administrative staff. We observed there was a display on the notice board in the reception area to remind staff of these principles.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw that all of the patients with dementia had a care plan in place and 80% of these had received their annual review so far this year. We also discussed care planning for people with learning disabilities with one of the GP Partners who had attended a learning disability awareness course in September 2014. This had led the GP to instigate a new system of care planning with these patients and half of the patients with learning disability had so far been involved in developing new care plans with the GP.

Good

Are services effective?

(for example, treatment is effective)

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 18% of patients in this age group had taken up the offer of the health check.

The practice had identified patients who needed additional support, and was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and a GP partner was taking the lead in ensuring that these patients were supported to engage with healthy lifestyle advice. They showed us they had referred some patients with learning disabilities to a local scheme promoting regular exercise.

The practice had also recorded the smoking status of 90% of patients over the age of 16 and a smoking cessation clinic was available at the practice for patients who smoked. In the current year (2014/2015) support had been given to 63% of smokers and to 73% of smokers with chronic disease. These levels were high, but were somewhat short of the QOF target for the current year (2014/2015) of 90% by the end of March 2015. The practice was performing well in relation to other QOF health promotion or ill-health prevention targets. For example, the practice's performance for cervical smear uptake was 84%, which exceeded the 80% QOF target.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was aware that they had had low levels of uptake of flu vaccinations amongst higher risk groups, including young children. Data from the previous year's QOF submission (2013/2014) showed that 34% of people deemed in the high risk groups had had the vaccination which was lower than the local average (52%). The practice could demonstrate they had taken steps to address this issue. They had met with representatives from the local Clinical Commissioning Group (CCG) to discuss plans for increasing uptake. The practice had implemented a number of strategies to increase uptake including contacting patients via letters and phone calls as well as publicising the flu vaccine on the website and in the waiting area.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and the majority were positive about the care they received. Patients told us they had good relationships with the doctors and administrative staff. Staff were kind and caring and treated patients with respect. We spoke to two patients on the day of our inspection who were also members of the Patient Participation Group (PPG). They highly rated and valued the care provided by the practice. We also spent time in the reception area and observed that staff spoke to people respectfully.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (January 2015). 92% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. This compared well against the local average (85%). 95% of respondents reported that the last GP they saw or spoke to was good at listening to them, which was also above the local average (89%).

We discussed the survey results with the practice manager and GP partners. They told us they reviewed the results to identify any areas for improvement. For example, the previous survey results (July 2014) had shown that only 10% of respondents stated that other patients could not over hear their discussions in the reception area. The practice manager had provided reception staff with additional guidance on how to keep discussions confidential, including offering to see patients in a quiet room or separate corridor. Staff had also attended a customer care course. The reception staff we spoke with referred to this guidance and had put it into practice. They felt it had improved patients' experiences. They placed a high value on the additional training course because it had improved their skills when working with patients at the reception desk. This question was not included in the most recent survey so we could not quantitatively establish the impact of these changes.

The practice had taken steps to ensure that patient records were kept confidential. Paper records and computers containing patient information were faced away from the public areas and behind swing doors which separated the waiting area from the receptionist's computer work stations. Staff had received information governance training including guidance on data protection and confidentiality.

Reception and clinical staff were available to act as chaperones by being present during a medical examination or procedure. There was a notice in the waiting area informing patients of this service, although this information was not also displayed in the consulting rooms. The reception staff we spoke with told us they acted as chaperones on a regular basis; performing this duty each week. This showed that patients were aware of this service.

Although the GP partners were both female, there were male GPs working at the practice. Patients could request to see a GP of a particular gender if they wished to do so.

Treatment room doors were shut during consultations and conversations taking place in these rooms could not be overheard. There were disposable curtains in consulting rooms so that patients' privacy and dignity could be maintained during examinations.

Care planning and involvement in decisions about care and treatment

The patient survey information (January 2015) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. 87% of respondents reported that the last GP they spoke to was good at explaining tests and treatments. 84% said the GP was good at involving them in decisions about their care. This was above the national average (82% and 75% respectively). However there were some areas where the practice could improve. For example only 72% of respondents reported that the last nurse they saw or spoke with was good at involving them in decisions about their care, which although higher than the national average (66%) was somewhat below the local area average of 82%. The GP partners had identified this as an area for improvement and were considering how they could respond. They noted that the score had improved from the previous results (July 2014) by 5%.

The patients we spoke with told us their GPs knew them well and were careful to check that they understood the implications of different treatment options. They felt confident in discussing their care with their GP and could raise any questions or concerns when they needed to. They told us GPs responded to their questions and concerns

Good

Are services caring?

with good quality information which they could understand. The comment cards we reviewed frequently referred to all staff being helpful and included comments about doctors listening to their concerns and giving good advice.

The practice had developed detailed care plans for people with complex needs including those with long-term conditions, elderly or frail patients, and those with learning disabilities. They all received regular reviews. For example, we saw that 12 out of 15 patients who had been diagnosed with dementia had had a review within the past year. Care plans had been developed in discussion with the patients, although copies were not routinely supplied to patients.

Reception staff told us they had access to translation services for patients who did not have English as a first language. They knew how to arrange this service. They could also arrange for someone proficient in sign language (Makaton) to support people during a consultation, if necessary.

Patient/carer support to cope emotionally with care and treatment

There were notices in the waiting area which told patients how to access a number of support groups and organisations. The practice was actively trying to identify people who were registered with them and were carers. There was a notice in the waiting area asking carers to complete a form so that a GP could contact them to offer further emotional or practical support.

The practice hosted sessions for two psychologists working for the Improving Access to Psychological Therapies (IAPT) service in order to provide additional support to those experiencing some mental health issues. The practice also identified and monitored patients with poor mental health, including patients with dementia. These patients had alerts placed on the shared computer system so that they could be prioritised for appointments.

Patients nearing the end of their lives were discussed at quarterly meetings in conjunction with the community nursing team. Patients concerns and wishes for the future had been discussed and a plan had been co-ordinated across the range of professionals who might become involved in providing some care to palliative patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The GP partners demonstrated they understood the needs of their practice population. They discussed their assessment of these needs and provided us with data which supported their assessment. For example, the practice had analysed the distribution of the practice population in terms of age and gender. This had shown them that they had relatively high numbers of working age people and young children registered with the practice. There were systems were in place to address identified needs in the way services were delivered.

The practice offered a range of clinics to meet the needs of their local population. This included a diabetes clinic, a warfarin clinic, phlebotomy, spirometry, methotrexate monitoring and post-natal and family planning clinics, and the fitting of intrauterine devices (IUD). The practice had implemented extended opening hours to meet the needs of working people and families.

There were a number of ways in which the practice received feedback from their patients. The practice reviewed data from the national patient survey and had carried out their own in-house survey in 2014. The practice was also monitoring response to the 'Friends and Family Test'. This is a short survey which all GP practices are asked to use in order to collect patient feedback. The most recent data showed that 92% (35/38 responses) of patients were likely to recommend the practice to others.

The practice had an active Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have an interest in the services provided. The PPG met regularly and we saw minutes from a meeting where the need for opening for extended hours was discussed. The practice had also developed a 'virtual' online group of patients who could be consulted about such matters.

The practice liaised regularly with the Wandsworth Clinical Commissioning Group. One of the GP partners was the Clinical Lead at the CCG for the Battersea area and set aside time each week to work with the CCG.

Tackling inequity and promoting equality

The practice manager and one of the GP partners had completed an equality and diversity training course and were responsible for promoting an equality and diversity agenda at the practice.

The majority of the practice population were English speaking. However, the practice had access to language interpreters for people who did not have English as a first language. They could also arrange for someone with sign language expertise (Makaton) to attend appointments with people who needed this service.

The needs of the practice's relatively larger population of families with young children had been considered. For example, the practice supported the needs of breast-feeding mothers by promoting a breast-feeding friendly policy in the waiting area and through provision of a more secluded area, on request, for breast feeding.

The premises were accessible to patients with disabilities. For example, there was an entrance bell and push button at wheelchair height at the entrance. The consulting rooms were on different levels and on different floors. However, one part of the building had been made accessible through the installation of a lift. If people needed to be seen by clinicians on the ground floor there was a free consulting room which was assigned for this purpose.

The waiting area could accommodate patients with wheelchairs and prams. There were accessible toilet facilities on the ground floor, and this area had baby changing facilities. The waiting room had some child-friendly areas with toys and books available.

Access to the service

Appointments were available from 7.30am to 8.30pm Monday to Thursday, from 8.00am to 6.30pm on Friday and from 8.30am to 11.00am on Saturdays. This information was displayed on the practice website and in the patient information leaflet available in the waiting area. Patients could book appointments in person, online or over the phone.

Reception staff showed us the appointment booking system. They told us there were some appointments available on the day and others which could be booked up to three weeks in advance. We saw that there were still appointments available to be booked for the following day. The receptionists told us that if someone needed to be urgently seen they could be added to the end of the

Good

Are services responsive to people's needs?

(for example, to feedback?)

session list so that they could always be seen by a clinician. They also operated a telephone triage system whereby reception staff collected a list of people that needed to be called on that day by the GP to be assessed for either a home visit or urgent appointment at the surgery.

Patients with complex needs, for example, those with living long-term health conditions or those who had been identified as being at risk because of a mental health condition or vulnerable circumstances, were flagged on the computer. Reception staff could then book a longer appointment or prioritise appointments for these people.

The practice had carried out an in-house patient survey in 2014 to identify any patient concerns with the appointments system. They had found that patients were not always aware of the extended opening hours offered by the practice in the early mornings or evenings. The practice had taken some steps to advertise this service more widely. For example, we observed the information was displayed on a screen in the waiting area. The practice had also responded to the needs of its relatively large working-age population with young families by implementing a Saturday morning surgery session. Other changes that had been made included investing in an additional phone line to improve call response times and rectifying a problem with the text reminder service.

The comments cards we reviewed were generally positive about access to the service. The patients we spoke with told us they had good access to a named GP of their choice. However results from the national patient survey showed that only 39% of respondents with a preferred GP reported that they usually got to see or speak to that GP, which was below the local area average of 57%. This data had only recently been published and the practice was considering its response.

Listening and learning from concerns and complaints

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

Information about how to make a complaint was available in a leaflet displayed on a red comments box in the waiting area. The patients we spoke with had not needed to make a complaint, but they were aware of the process to follow if they wished to do so.

Reception staff told us they tried to resolve any patient concerns promptly at the time that an issue was raised. They also reminded people of their right to make a complaint in writing to the practice manager. If people did not want to write in but wanted their complaint recorded the reception staff would write it for them. If the practice staff were concerned about any of the verbal concerns raised by patients there were forms available for them to fill in and give to the practice manager to review.

We saw that the practice had received three written complaints in the last 12 months, and seven complaints had been received in the previous year. The three complaints received this year had all been investigated by the practice manager. She had held discussions with relevant members of staff and recorded the outcomes of these discussions. She responded promptly to complainants in writing with a description of the findings and any actions that had been taken.

The practice reviewed complaints annually at a practice meeting to detect any themes or trends and to review the actions that had been taken. We saw that the last review had taken place in January 2015. No patterns had been identified, but lessons learnt from individual complaints had been acted on.

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. The details of these were described in the practice's statement of purpose and in the practice charter which was available for patients to review in the waiting area. The practice had a number of stated aims including the provision of a high quality service in a confidential and safe environment, the promotion of patients' health and wellbeing through education and information, the involvement of patients in decisions about their treatments, and the provision of care in a respectful manner which was sensitive to people's beliefs and values.

The staff we spoke with were aware of the practice charter and shared the values outlined in it. Staff felt valued and told us they enjoyed their work. Most of the staff had worked at the practice for a number of years reflecting their level of commitment. We observed that all members of staff appeared friendly, approachable and polite with each other and when interacting with patients. This illustrated a positive, patient-focussed culture in the practice which was corroborated by the positive feedback we received from patients we spoke with during our inspection and in the comment cards.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. We spoke with seven members of staff and they 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 had a number of policies and procedures in place to govern activity. For example, the practice had policies in place for key safety issues including safeguarding, infection control, and health and safety. These were regularly reviewed to ensure that they were up to date with current guidance and key contacts. The practice had a significant events monitoring and analysis policy in place, which had been updated in March 2015.

Different members of staff were assigned separate policies for review depending on their roles and responsibilities. The practice manager checked that policies were read by staff through the use of an electronic monitoring system.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice had completed two cycles of an audit examining the numbers of intrauterine devices (IUD) fitted for contraceptive purposes. The audit cycle had been used to successfully improve the numbers of women returning for their six-week check following insertion. The practice also 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.

The practice had arrangements for identifying, recording and managing risks. The practice could demonstrate that they had a good patient safety record over time. However, there were some areas where safe systems were either not in place or the correct protocols were not being followed. For example, vaccine and other medicines storage arrangements did not meet current safety standards and staff had not followed the procedures for reporting identified risks to safe medicines storage. Fire safety issues had been identified but not addressed in a timely manner.

Leadership, openness and transparency

We saw from minutes that clinical team meetings were held weekly and administrative staff met approximately every two months. Staff also told us there were meetings on a roughly quarterly basis where administrative and clinical staff came together to discuss the smooth running of the practice.

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. There was a whistleblowing policy in place which staff were aware of and a staff handbook which could be referred to for guidance. Clinical and non-clinical staff told us the management team, including the practice manager and two GP partners, were all approachable and listened and acted on any concerns they raised.

Practice seeks and acts on feedback from its patients, the public and staff

Are services well-led?

Good

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

The practice was engaged with the Wandsworth Clinical Commissioning Group (CCG), with one of the GP partners acting as the Clinical Lead for Battersea. The partner set aside time each week to liaise with the CCG and attend meetings. The practice could also show that it was actively engaged with local hospitals and other care providers such as health visitors. The practice used these connections to share information, promote positive health outcomes for its patients and disseminate best practice guidance.

The practice gathered feedback from patients through a variety of sources including face-to-face meetings with the Patient Participation Group, consulting the 'virtual' patient group online, carrying out and analysing patient surveys and monitoring responses to the Friends and Family Test. The practice could demonstrate how they had implemented changes at the practice on the basis of their analysis of this feedback. For example, the practice had implemented extended hours sessions during the week and at the weekend in response to the needs of their local working-age population.

The practice had gathered feedback from staff through the use of an annual staff survey prior to appraisals being carried out. Staff told us they were confident about giving feedback and felt involved and engaged by the management in the running of the practice with a view to maintaining a high quality experience for patients and staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The GPs provided peer support to each other and accessed external support from the CCG to help improve care delivery.

We looked at three 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 and that they attended courses to keep their skills up to date on a regular basis. We reviewed a list of training courses completed for each member of staff and saw this was the case.

The practice had good systems in place to review and learn from incidents and complaints. These were discussed at annual staff meetings to monitor for common themes and review the effectiveness of actions that had been put in place to prevent any problems from occurring again.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that people the practice had not protected people against the risks associated with the unsafe use and management of medicines by means of making the appropriate arrangements for the safe keeping of medicines. This was because some medicines were not securely stored and in such a way as to ensure that they could not be accessed by members of the public. In addition, the practice could not, at the time of the inspection, be assured that vaccines were stored in line with national guidance and improvements were needed in the monitoring of vaccine storage. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that people who used the service and others were not protected against the risks associated with unsafe or unsuitable premise by means of appropriate measures in relation to the security, adequate maintenance and operation of the premises. This was because the provider had not promptly responded to fire safety recommendations. This was in breach of regulation 15(1)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the practice did not take proper steps to ensure that service users were protected against the risks of receiving treatment that was inappropriate or unsafe, by means of the delivery of treatment in such a way as to ensure the welfare and safety of the service user. This was because Patient Group Directions and Patient Specific Directions in use in the practice did not meet with the legal requirements. This was in breach of regulation 9 (1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.