

Violet Lane Medical 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

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Overall summary

Letter from the Chief Inspector of General Practice

Letter from the Chief Inspector of General Practice

Violet Lane Medical Practice is a GP practice based in Croydon. The practice provides primary care services to 10,500 patients. We carried out an announced comprehensive inspection on 13 October 2014.

We inspected The Violet Lane Medical Practice site. The practice has no other sites.

Our key findings were as follows:

- Overall the practice is rated as good. However improvements are required for safe because reception staff acting as chaperones did not have Disclosure and Barring Service (DBS) checks. However risks to patients were assessed and well managed and there were enough staff to keep people safe.

- The practice provided evidence based care with reference to guidance from organisations such as National Institute for Health and Care Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation.
- The practice provided support to its patients during periods of bereavement. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The practice had a Patient Participation Group (PPG). The PPG members told us that the practice worked closely with them and their views were taken on board.

The practice reviewed the needs of their local population and engaged with the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

We found that the practice had a clear vision and strategy to deliver care. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

Summary of findings

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

Importantly, the provider must:

- Action Ensure that reception staff acting as chaperones have current Disclosure and Barring Checks (DBS) Reg 21.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for safe as reception staff acting as chaperones did not have Disclosure and Barring Service (DBS) checks. However risks to patients were assessed and well managed and there were enough staff to keep people safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses.

Requires improvement



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs have been identified and planned for. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and received good 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 an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision

Good



Summary of findings

and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). 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

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. All patients aged 75 and over had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of direct enhanced services that were designed to reduce hospital admissions. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. The GPs followed up all patients discharged from hospital within 24 hours to check they had all the medicines required.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, parents or representatives of children and young people who had a high number of A&E attendances received follow up telephone calls from the nurses. Immunisation rates were relatively high when compared with local performance for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

The practice had a midwife who attended once a week to offer antenatal care.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and this included 45 patients with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 100% of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good



The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). 52% of people experiencing poor mental health had received an annual physical health check. The practice told us they had scored slightly low in this area due to the number of patients moving addresses and not notifying them. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice offered these patients opportunistic cervical smear checks, flu vaccinations and other health and well-being checks.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations

Summary of findings

including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for patients with mental health needs and patients with dementia.

Summary of findings

What people who use the service say

The Patient Participation Group (PPG) members and the patients we spoke with on the day of our visit told us that they were treated with kindness and respect by all staff at the practice. The PPG members said that they had regular meetings and that the practice staff engaged with their group.

We received 10 completed comments cards and spoke with six patients. All patients reported being happy with the care and treatment they received. All patients we spoke with were complimentary on the attitudes of all staff and reported feeling “well cared for” and respected.

Patients reported being happy with the appointments system which they felt suited their needs.

Areas for improvement

Action the service MUST take to improve

Action the provider MUST take to improve:

Ensure that reception staff acting as chaperones have current Disclosure and Barring Checks (DBS).

Violet Lane Medical Practice

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 GP and a practice manager.

Background to Violet Lane Medical Practice

Violet Lane Medical Practice is a medium sized GP practice based in Croydon. The practice provides primary care services to 10,500 patients. The ethnicity of patients is mainly white British with small numbers of Asian and Black Caribbean patients.

In Croydon male life expectancy is 78.9 years and female life expectancy is 82.2 years. Both are above the England average for both males and females. Death rates from all causes are falling at approximately the same pace across the borough. However, there has been little change in the gap in life expectancy between the most deprived areas and the least deprived areas between 1995 and 2008. The main causes of death in Croydon are circulatory diseases, cancers and respiratory diseases.

The early death rate from all cancers in those under 75 years old is below the London and

England averages. However, those in the most deprived areas of Croydon have a much higher rate of death from all cancers than those living in the least deprived areas.

The practice is located in a purpose built building that was renovated a few years ago to increase space. The practice is open from 08:00 am to 18:00 pm on weekdays. Extended are available on Wednesdays and Thursdays until

20:30pm. The practice is registered to offer the following regulated activities: Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The practice has four full time male GPs and two full time female GPs. The practice has seven reception staff, a full time practice manager, one health care assistant, a medical secretary and two practice nurses providing 77 hours of care per week and one nurse practitioner.

The practice holds a Personal Medical Services (PMS) contract for the delivery of general medical service. Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice. PMS contracts offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).

The practice have opted out of providing out-of-hours services to their own patients. A local out of hours service was used to cover emergencies and patients could access it via the 111 service.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 October 2014. During our visit we spoke with a range of staff such as GPs, practice manager, practice nurse and administrative staff, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We received 10 completed patient comments cards. We also viewed patient records

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. This included, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example an issue with patient monitoring data not being recorded accurately was raised as an incident. This was then followed up with an action plan for improvement which required a second staff to double check entries for accuracy.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred once a month to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to ensure these were managed and monitored. We tracked one incident and saw records were completed in a comprehensive and timely manner and that action was taken as a result.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example a safety alert had been received on the withdrawal of medicines used for

epileptic patients. On receiving this alert the practice manager had sent a message to the practice nurse to action. The practice nurse audited the records and identified patients who would have been affected. We saw that appointments were booked for these patients and information on medicine changes were discussed and the GPs prescribed alternative medicines.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children. During our inspection the lead safeguarding GP was on leave but arrangements were in place to ensure suitable cover during their absence so that staff had a nominated contact. We spoke with the deputy lead safeguarding GP who had been trained and could demonstrate they had the necessary skills to enable them to fulfil this role.

All clinical and non-clinical staff we spoke with were aware of who the lead person was and who to speak to in the practice if they had a safeguarding concern.

Training records showed that all staff had received relevant role specific training in safeguarding children and adults. All GPs at the practice had received Level 3 child protection training. The practice nurses had received Level 2 child protection training and reception and administration staff had all received Level 1 training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details of the local safeguarding teams were easily accessible to staff through display on notice boards.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans would have an alert set up on their records to ensure continuous monitoring was in place and they could be easily identified for specific safety purposes.

A chaperone policy was in place and on display on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing

Are services safe?

staff. All receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. However administrative staff who were acting as chaperones had not had Disclosure and Barring Checks (DBS) or been risk assessed for carrying out this role.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. Records showed that the fridge temperatures were checked and recorded. All recordings for the past 12 months were within the required range.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas, including how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient.

The practice had carried out audits to ensure this was being adhered to. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and annual updates thereafter. We saw evidence the lead had carried out annual audits for the last two and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. There was also a policy for needle stick injury. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Alcohol hand gels were also available in all patient waiting areas to reduce the risk of infections.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

We saw records and equipment maintenance logs that confirmed all equipment was regularly tested. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of November 2013. A

Are services safe?

schedule of testing was in place. We saw evidence of calibration of equipment such as weighing scales and the fridge thermometer. This had been completed in October 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all clinical staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body, and criminal records checks via the Disclosure and Barring Service. However administrative staff who were acting as chaperones had not had any DBS checks completed. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure they was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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 ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there as an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an audit that had resulted in improvements to the processing of patient results.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly by a designated staff and arrangements were in place for cover during absences.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of chronic diseases. The review of the clinical meeting minutes confirmed this happened.

The practice used a template provided by the CCG when undertaking health reviews for chronic patients to ensure they followed current evidence based guidelines with the aim of improving care outcomes. Diabetes was one such condition as it had been identified as a local priority area by the CCG. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within three weeks by their GP according to need. We viewed records which demonstrated the practice was meeting this requirement.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers; patients were referred and seen within two weeks. Meeting minutes showed elective and urgent referrals were regularly reviewed and discussed to ensure that any learning or improvements were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

An example of a clinical audit was on inadequate cervical smear tests completed in March 2014. The practice had found that the rate of inadequate smears had increased. An inadequate smear test occurs when a sample on the microscope slide is unsuitable for analysis and the patient has to have a repeat sample taken. The audit looked at the staff members who were taking the samples. They found that one staff member had a higher inadequate rate than all other smear takers. As a result of this audit, further training needs had been identified and implemented. A repeat audit was planned for the end of year to ensure that improvements had been made in smear sample taking.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) to monitor its performance against national screening programmes (QOF is a national performance measurement tool). For example, 68% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma, and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF or other national clinical targets.

The practice team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year. All clinical staff had each undertaken at least one audit per year as required.

Are services effective?

(for example, treatment is effective)

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

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 annual basic life support. All GPs were up to date with their yearly continuing professional development requirements. Some had been revalidated in 2015 and others were due for revalidation in 2016 and 2017. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice had records supplied by the practice nurses that showed their registration with the Nursing and Midwifery Council (NMC) was current.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurses were supported to access training in areas they had identified such as chronic disease management and smoking cessation.

The nurses were also part of a local cluster that shared information and developments in clinical updates.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any

issues arising from communications with other care providers on the day they were received. The duty GP was ultimately responsible for reviewing and acting upon test results. We reviewed the process for checking blood results. Records confirmed that there were no instances within the last year of any results or discharge summaries which were not followed up appropriately. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service to ensure patients discharged from hospital were appropriately followed-up. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). The GPs followed up all hospital discharges within 24 hours of discharge letters being received.

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

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The practice had systems in place to provide staff with the information they needed. An electronic patient referral system called CReSS (Croydon Referral Support Service) was used locally. The system helped to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities 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.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. These examples were for patients with Dementia who had been recently diagnosed and referrals had been made to social workers to ensure a nominated person was available to make best interest decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (Gillick competence is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). Staff gave us examples such as not allowing parents access to records for children aged 16 and over.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and the identified patients were followed -up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental

health, physical health and wellbeing. They offered opportunistic chlamydia screening to patients aged 18-25 and smoking cessation advice to smokers. The practice offered patients a wide range of health promotion leaflets. These were displayed in the waiting rooms. Leaflets available included dietary advice and support groups for weight loss, travel information and vaccinations, chronic disease management for asthma, diabetes, epilepsy, and sexually transmitted diseases.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all had been offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months.

The practice's performance for cervical smear uptake was 81% and was better than other practices in the area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance for childhood vaccines uptake was 93.% and the average in the CCG was 89.9%. The practice was part of a scheme that sent reminders for children`s vaccinations to parents termed "vaccination birthday card". Staff told us that this was helpful as it reminded parents to book outstanding vaccinations. The nurses were also responsible for making follow up contact to parents of children who failed to attend.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. Data from the national patient survey showed that 94% of patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice had scored well in this area as the local CCG rate was 90%.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 10 completed cards and all the patients were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 88% of practice respondents said the GP and nurses involved them in care decisions and 75% felt the GP was good at explaining treatment and results. Both these results were above the Clinical Commissioning Group (CCG) average.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception area informing patients that this service was available. A hearing loop service was available for patients who needed it.

All clinical staff were aware of their role in assisting patients to make best interest decisions. They understood the Mental Capacity Act 2005 and the concept of Gillick Competency. Gillick competency is a term used in medical law to decide whether a child 16 years or younger is able to consent to his or her own treatment. Examples given to support the use of these concepts related to care for patients with dementia, those with experiencing poor mental health and situations were children aged below 16 would request contraception.

Patient/carer support to cope emotionally with care and treatment

Patients were supported by the practice during times of bereavement. We saw notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and signposting to a support service.

Are services caring?

Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. The GPs also referred patients who had been identified as requiring support for counselling.

During patient registration the practice noted down details of carers. This was to ensure they were offered all support

and information relating to patient and carer support information. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used the Croydon Referral Support Service (CReSS) risk tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities. The Clinical Commissioning Group (CCG) had identified diabetes as a local priority. As a result, all new patients identified as being at risk were offered screening. The nurses and the health care assistant offered reviews of diabetic patients, which included them being offered a foot assessment and eye test referrals. The practice had also identified that a small number of their diabetic patients required support during religious observations such as Ramadan. These patients' cultural beliefs required them not to eat at certain times. This would affect the management of diabetes. The nurses took time to offer advice to these patients and encourage regimes that both supported their beliefs but also taking into account of their health needs.

The CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. We saw that the needs of patients experiencing poor mental health had been identified as requiring prioritising. GPs told us that they had found it difficult to engage with the community mental health teams. This was mainly due to their location in the borough and the service delivery changes they were going through. However the practice had continued to work closely with other providers such as local hospitals.

There had been very little turnover of staff during the last 10 years which enabled good continuity of care and accessibility to appointments with a GP of choice. The practice had a mix of female and male GPs. This gave

patients choice of being seen by a preferred GP. However, results from the national patient survey showed that 64% of respondents reported being able to see a preferred GP, the average for practices in the CCG area was 74 %.

Longer appointments were available for people who needed them and those with long term conditions. The nurses booked longer appointments for all the chronic conditions patients. This allowed enough time to discuss concerns. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. Flu vaccinations were also offered at home for those patients who were too ill to come to the practice.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. Information for those patients that had attended services such as, out of hours, accident and emergency and other hospitals was shared electronically. A system was in place that scanned these records onto individual patient records to ensure continuity of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Online appointments booking was available. This was particularly useful for the working age population. The practice offered emergency appointments to parents of school age children. Services such as child vaccinations, cervical screening and well man and woman checks were offered during evening extended hours, as well as during regular hours. This enabled the working population or those not able to attend during the normal working hours the same access.

All patients we spoke with and feedback from the comments cards showed that patients were happy with the appointments system. Results from the national patient survey showed that 91% of respondents at the practice described their experience of making an appointment as good, compared to 74 % from the local area. Staff at the practice told us that they continually sought feedback from patients to ensure the appointments system was suitable for patients needs.

The practice provided GP services to patients from two local residential homes for people with mental health conditions.

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

Appointments were available from 08:00 am to 18:00 pm on weekdays. Extended hours were available on Wednesdays and Thursdays until 20:30pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients we spoke with were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. We looked at the appointments available on the day of our inspection. It was evident that provisions for emergencies were made for patients.

All patient services at the practice were available on the ground floor of the practice.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and

allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice mainly had English speaking patients, but was able to cater for other different languages through translation services.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, including a section in the practice leaflet and a notice in the practice reception area. Patients we spoke with were aware of the process to follow should they wish to make a complaint, although none had ever needed to make a complaint about the practice.

The practice had received a total of three complaints in the last twelve months. We found these handled in a timely way and satisfactory manner.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG contained representatives from various population groups; including the retired and working age population. They told us that they had not conducted any surveys but felt the practice listened to suggestions they made.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's business plan. These values were clearly displayed in the waiting area and in the staff room. The practice vision and values included offering a friendly, caring good quality service that was accessible to all patients.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice meetings and saw that staff discussed and shared the values on a regular basis to ensure they all worked towards them

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at all of these policies and procedures and all staff had signed and dated a cover sheet to confirm they had read the policy. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice held governance meetings every three months. We looked at minutes from the last 12 months and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice had allocated each clinical staff member an area of expertise and they were responsible for the monitoring and development of ideas to improve performance

The practice had completed a number of clinical audits, for example the nurses had carried out an audit on the quality of cervical screening tests. As a result of this audit, further training needs had been identified and implemented. A repeat audit was planned for the end of year to ensure the training had been effective and there were improvements in the quality of cervical screening checks.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as the processing of patient results in a timely manner. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example the practice had a protocol for dealing with seriously ill patients who attended the surgery. Guidance had been developed for staff to assess the symptoms immediately and either inform a doctor or call for an ambulance.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality, harassment, and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The Patient Participation Group (PPG) met every quarter, but had not carried out any surveys. A member of the group told us that they frequently feedback to the practice manager any concerns they had and this was acted on. For examples we were told that the practice had made more information on local support groups available after the PPG had identified the need for patients to have a list of local resources they access.

Are services well-led?

Good 

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

The practice had gathered feedback from through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six 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 .

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>Regulation 21 HSCA (Regulated Activities) Regulation 2010 Requirements Relating to Workers.</p> <p>How the regulation was not being met:</p> <p>The registered person failed to ensure that there were effective recruitment procedures in place in order to ensure that people employed in the service were of good character. Regulation 21 (a) (i)</p> <p>Staff acting as chaperones did not have Disclosure and Barring Service checks.</p>