Bermondsey and Lansdowne Medical Mission

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bermondsey and Lansdowne Medical Mission on 22 April 2015, which included a visit to the branch surgery The Artesian. Overall the practice is rated as good.

Specifically we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was outstanding for providing services to older people and good for providing services to people with long term conditions; families, children and young people; working age people and those recently retired and students; people whose circumstances make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Patients said that they were treated with kindness and respect, their dignity was maintained, they were involved in decisions about their care and treatment and said staff were caring;
- Information about the services provided, how to get involved with the Patient Participation Group and how to complain were available and easy to understand;
- Patients reported good access to urgent on the day appointments, however they expressed concerns over the length of time they had to wait for a routine appointment with their preferred or named GP;
- Staff understood and fulfilled their responsibilities to report incidents and raise concerns;
- Risks to patients were assessed and well managed;
- There were clinical leads for the common health conditions experienced by patients at the practice including a diabetes specialist GP who provided support for patients with complex diabetes;
- Systems were in place for clinical staff to keep up to date with best practice guidance;
- Data showed the practice was above and in line with national and local averages;
- Systems were in place for audit cycles to be completed with the information shared with all GPs.

We saw several areas of outstanding practice including:

Summary of findings

- The employment of a specialist nurse co-ordinator for older people, who carried out home visits for housebound patients, worked with other health and social care providers to ensure joined up care and was able to signpost patients and their carers to local support services;
- The support given to patients receiving end of life care and the patients relatives and carers.

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

In addition the provider should:

- Ensure the risk assessment regarding Disclosure and Barring Service checks for non-clinical staff who may carry out a chaperone role considers if these staff would be left alone with patients;
- Improve the system to check emergency medicines are in date;
- Provide infection control training for the cleaner;
- Apply to CQC to make the required changes to the practice registration.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Systems were in place to report and record incidents and staff were aware of their responsibilities to raise concerns and report incidents and near misses. Suitable arrangements were in place for safeguarding with policies in place and staff being suitable trained. However, while risk assessments were in place regarding the need for administrative staff to have a Disclosure and Barring Service check these did not consider if the staff member would be left alone with patients. Arrangements for medicines management required improvement to the checks on emergency medicines. Fridge temperatures were recorded and seen to be within the required range. Staff recruitment was in line with requirements and there were systems to ensure there were enough staff. Suitable arrangements were in place to deal with a range of emergencies with risk assessments in place and kept under review.

Are services effective?

Good

The practice is rated good for providing effective services.

We found systems were in place to keep clinical staff up to date with both the National Institute of Health and Care Excellence guidelines and other locally agreed guidance. Data showed the practice was performing in line with and above other practices in the local area. There were lead GPs for a number of common health conditions experienced by patients at the practice. Staff had access to training to help them carry out their role. Systems were in place for administrative, nursing and health care staff to receive an annual appraisal. The practice linked with other health and social care services to provide joined up care to patients with complex health needs and evidence showed they provided good care and support to patients receiving end of life care and their relatives and carers. The practice provided a range of health promotions in the forms of education sessions, leaflets and information for patients to help them control and manage their health conditions.

Are services caring?

Good

The practice is rated good for providing caring services.

Patients said that staff maintained their privacy and dignity and they felt they were treated with respect. We saw staff spoke politely and appropriately to patients. Patients said they were involved in decisions about their care and treatment. Results from the 2014 GP

Summary of findings

survey showed 78% of respondents said that the last GP and 81% said the last nurse they saw or spoke to was good at involving them in decisions. Seventy one per cent of respondents said their overall experience at the practice was good or very good.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services.

The health needs of the patient population were known and services were developed to meet them. The practice engaged with the local Clinical Commissioning Group (CCG) to identify improvements required to healthcare in the local area. Both the surgery and branch were accessible to patients with mobility problems with room for wheelchairs and pushchairs. Staff had access to telephone and on-line translation services. A Patient Participation Group was in place. This group met six times a year and were involved in seeking patient's views on the services provided. The practice was open five days a week Monday to Friday from 8.00am-6.30pm with extended hours provided at the branch surgery from 6.30-8.00pm Tuesday and Wednesday evenings. When the practice was closed the answer machine directed patients to ring the out of hours service. A range of book in advance and urgent on the day appointments were provided. Patients made positive comments about access to urgent appointments although were less satisfied with the time they needed to wait for routine appointments with their preferred GP. Patients were satisfied with the repeat prescription process. The practice manager was responsible for dealing with complaints. Suitable arrangements were in place to respond to complaints in a timely manner. Records showed complaints were responded to and learning points were shared with staff.

Are services well-led?

Good

The service is rated good for providing a well led service.

There was a clear vision and strategy for the practice. Staff were clear about the vision and their roles and responsibilities in relation to this. There was a clear leadership structure and staff said that they felt supported by the partners and able to go to them for advice and support. There was a low staff turnover although recent retirements had left some vacancies for senior reception staff. There was an active Patient Participation Group which met regularly and was involved in reviewing the Friends and Family Test comments received, reviewing patient surveys and developing action plans to improve the patient experience. Systems were in place to identify risk and monitor and improve quality. There were regular clinical,

Summary of findings

nurses, staff and partners meetings during which minutes were taken so anyone not attending was kept up to date. Governance arrangements were in place which included the required policies and procedures to govern activity.	

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

Outstanding 

The practice is rated outstanding for the care of older people.

Less than 3% of the practice patients were aged over 75. All patients over 75 had a named GP. There was a specialist nurse coordinator for older people, who signposted patients to a range of services. They attended monthly multidisciplinary team meetings to discuss patients' needs. The practice worked with the local hospital trust and referred patients for same and next day reviews with the rapid response team and consultant geriatrician to help prevent unnecessary hospital admission. The practice provided a range of book in advance and on the day urgent appointments and GPs and the specialist nurse coordinator provided home visits for patients who were not able to attend the practice. An annual home visit was carried out to ensure reviews of care and treatment were carried out. Systems were in place for regular medication reviews. Care plans were developed with people receiving end of life care, the details were shared with the out of hours provider to ensure they were updated to any changes. Seventy five per cent of patients over 65 received their flu vaccination in the 2014-2015 season which was above the national average of 73%.

People with long term conditions

Good 

The practice is rated good for the care of patients with long term conditions.

There was a named clinical lead for each long term condition who worked with one of the practice nurses, they reviewed each patient on the long term conditions registers at least annually. One of the GPs oversaw end of life care, working with the local palliative care team. Patients with a number of long term conditions were invited for one nurse led review instead of three or four reviews throughout the year, to reduce the number of times patients needed to attend the practice. They targeted patients with long term conditions to have the flu vaccine. The practice provided a range of urgent on the day and book in advance appointments and longer appointments were provided when necessary. The practice worked with other health and social care providers to ensure patients with complex health needs received joined up care and treatment. Patients could be referred to physiotherapists and an osteopath at the practice.

Families, children and young people

Good 

The practice is rated good for the care of families, children and young people.

Summary of findings

The practice provided urgent on the day appointments and appointments outside of school hours. Systems were in place to identify children in disadvantaged circumstances including those who are at risk and this was clearly recorded so all staff were aware. Baby and childhood immunisation rates for the practice were above and in line with the CCG average. Failure to attend appointments for immunisations were reported to the health visitor. The practice was accessible for families with pushchairs. The practice worked with midwives, who attended the practice once a week, to provide shared antenatal care and with health visitors to deliver the Healthy Child Programme. Staff told us that they treated children and young people in age-appropriate ways and we saw evidence to confirm this.

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 practice had a higher proportion of patients aged 20-44 than the national average. To meet the needs of working age people, the practice provided extended opening hours from 6.30pm-8.00pm two evenings a week at the branch surgery with two GPs and one nurse one evening and four GPs and one nurse the other evening and patients could request a GP telephone call back. Patients could book non-urgent appointments and order repeat prescriptions on-line. The practice invited all patients over 40 for the NHS Health Check, although had very low response rates, and continued to provide opportunistic screening for blood pressure, cholesterol and diabetes at routine appointments. Eighty one per cent of women had attended for a cervical smear test which was in line with national average.

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.

The practice had access to translation services to help them meet the needs of patients whose first language was not English. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. It had carried out annual health checks for 75% of people with a learning disability and offered longer appointments for these patients. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise

Summary of findings

signs of abuse in vulnerable adults and were aware of their responsibilities regarding information sharing and how to contact the relevant agencies. Arrangements were in place for the practice to register patients who were homeless.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health.

The practice held a register of patients experiencing poor mental health who had a named GP, 91% had a care plan which is above the national average of 86% that was reviewed annually. The practice worked with multidisciplinary teams in the case management of people experiencing poor mental health, making appropriate referrals to community mental health teams and holding three monthly meetings with relevant health professionals. Patients were signposted to local services and the practice had a linked drug worker who visited the practice weekly to manage prescriptions for patients on Methadone. Data showed patients were routinely asked about their alcohol consumption and smoking status which was recorded in the electronic patient record.

The practice had a register of patients with dementia, all of whom had a named GP who with the specialist nurse coordinator for older people provided support to the patient and their carers. Advanced care planning was in place for patients with dementia.

Summary of findings

What people who use the service say

We spoke with fifteen patients. We looked at results from the GP patient survey for 2014. The practice carried out their own survey in 2015 which had 167 responses.

Patients we spoke with gave mixed comments on their experience of the practice; some were very complimentary while others were not satisfied with the time they had to wait to get an appointment. Patients did say getting an urgent on the day appointment was not difficult. Patients said staff were polite and respectful that the GPs were competent and friendly and they were confident in the treatment they received. They said their privacy was maintained during appointments because consultation room doors were closed.

The results from the 2014 National GP survey involved 461 surveys being sent out, with 113 returned giving a 25% completion rate. Responses showed 60% of respondents with a preferred GP were usually able to see or speak to that GP; this was above the CCG average of 53%. Ninety three per cent of respondents said the last time they saw a nurse, they were good at giving them enough time and 91% said the last nurse they saw was good at treating them with care and concern, both were above the CCG average of 87% and 85%. Seventy one per cent of respondents said their overall experience at the practice was good, below the CCG average of 80%. Sixty nine per cent of respondents said it was easy to get through on the telephone, which was below the CCG average of 75%. The practice had made changes following patient feedback, introducing a triage system to improve the patient experience of making an appointment.

The results from the practice survey indicated 96% of respondents rated reception staff as ok to excellent and 76% said it was very or fairly easy to speak with reception staff over the telephone. Seventy two per cent said they saw GP on the day or the next day if urgent, others were not sure. Eighty seven per cent were aware how the appointment system worked, 96% said the care they received at their last visit was ok to excellent. Sixty eight per cent described their overall experience as excellent or good and 85 % said they understood the referral process.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the risk assessment regarding Disclosure and Barring Service checks for non-clinical staff who may carry out a chaperone role considers if these staff would be left alone with patients;
- Improve the system to check emergency medicines are in date;
- Provide infection control training for the cleaner;
- Apply to CQC to make the required changes to the practice registration.

Outstanding practice

- The employment of a specialist nurse coordinator for older people, who carried out home visits for housebound patients, worked with other health and social care providers to ensure joined up care and was able to signpost patients and their carers to local support services;
- The support given to patients receiving end of life care and the patients relatives and carers.

Bermondsey and Lansdowne Medical Mission

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP and a practice manager specialist advisor, an Expert by Experience a second CQC inspector and an observer from the Department of Health. The specialist advisors and Expert by Experience were granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Bermondsey and Lansdowne Medical Mission

Bermondsey and Lansdowne Medical Mission operate from The Surgery at Decima Street with a branch surgery, Artesian which is a ten minute walk away. The practice started as a medical mission providing free care for the needy and today they maintain this ethos. The practice had higher than national average numbers of children 0-4 years of age and people aged 20-44 years. The practice served a culturally diverse population, with 40% from a white British background, 9% from Asian and 8% from African backgrounds. Forty three per cent of patients have long standing health conditions, 10% have caring responsibilities and 78% of patients are in paid work or full time education. It is in the fourth most deprived area of England. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostic and screening procedures, family planning, maternity and midwifery, surgical procedures and treatment of disease, disorder or injury.

The practice provides primary medical services through a Personal Medical Services (PMS) contract. A PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice provides a range of services including family planning and contraception services, maternity services, child and adult immunisations to just over 15,000 patients in Southwark.

The practice is a member of Southwark Clinical Commissioning Group (CCG) and is one of 24 practices in the North Southwark CCG Locality. It comprises of four partner GPs and nine salaried GPs (two male and 11 female), four practice nurses and a part time healthcare assistant. There is a full time practice manager, eight administrative staff and eleven reception staff and a cleaner. The practice is a training practice.

The practice is open from 8.00am-6.30pm Monday to Friday with appointments available from 9.00am to 12.00noon and then from 3.00pm to 5.30pm on Monday to Friday with extended opening hours provided from 6.30-8.00pm Tuesday and Wednesday at the branch surgery. The GPs completed telephone consultations and home visits for patients. The practice has opted in to providing out-of-hours services to their patients through the local Cooperative, Seldoc (South East London Doctors Cooperative is formed of GP practices across Lambeth, Southwark and Lewisham)

Detailed findings

The practice needs to apply to CQC to update the registered partnership to reflect changes and to apply to remove the urgent care service from their registration.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider has not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 and asked other organisations to share what they knew. We carried out an announced visit on 22 April 2015. During our visit we spoke with 15 patients including three from the Patient Participation Group and a range of staff including three GP partners, three salaried GPs, four nurses, the health care assistant, the practice manager and assistant practice manager, two administrative and seven reception staff including the reception team leader. We spoke with the palliative care nurse, district nurses and health visitors who were visiting or based at the practice. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events and clinical audits. We looked at how medicines were recorded and stored.

Good

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 including reporting incidents, keeping up to date with national patient safety alerts and responding to patient's comments and complaints. These were discussed at the weekly clinical meeting and minutes confirmed this. Critical incidents were not recorded but discussed by team leaders at weekly meetings. Medicines and Healthcare Products Regulatory Agency alerts were received by the lead GP for prescribing which were passed on to relevant staff by email.

Staff we spoke with were aware of their responsibilities to raise concerns and the process to report incidents and accidents within the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and accidents. Records were kept of significant events going back to 2002, although the number reported was low until 2013. We reviewed the 17 completed in the last 12 months. Clinical staff presented significant event analysis at weekly clinical meetings which were minuted and minutes were shared amongst relevant staff. We saw new cancer diagnosis were discussed at clinical meetings and recorded as significant events. Records of one significant event showed there had been a failure of the fail safe system to alert patients of abnormal results. We saw this was actioned immediately, administrative staff made searches of the electronic patient records to identify any patients who may have been affected and each clinician carried out an audit of their referrals within a week of the issue being identified. A review meeting was held three weeks later when the event was analysed with positive points acknowledged and points for improvement identified and an action plan developed to change the way results were dealt with within the practice. Meeting minutes confirmed this was shared with staff who were present and those not able to attend the meetings held. The improvements made included staff receiving additional training.

Staff including receptionists, administrators and nursing staff were aware of the system for raising issues and felt encouraged to do so. We saw records of a recent incident and the actions the practice had taken and how the lessons learned were shared with all staff.

Reliable safety systems and processes including safeguarding

One of the GPs was the lead for safeguarding children and vulnerable adults. They had been trained and demonstrated they were able to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to within the practice if they had a safeguarding concern. The lead met with the health visitors on a regular basis to discuss issues regarding vulnerable children.

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. All GPs and nurses had received child protection training to Level 3 and non-clinical staff were trained to Level 1. The staff had also received training in safeguarding vulnerable adults. All staff we spoke with demonstrated a good understanding of safeguarding issues and their responsibilities and knew how to share and record safeguarding concerns and how to contact the relevant agencies both in and out of working hours.

There was a system to identify vulnerable patients on the electronic recording system. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to a child protection plan and those deemed vulnerable. Any safeguarding reports were given to the named GP for action with arrangements in place to cover when that GP was not at work.

There was a chaperone policy. This was displayed on the waiting room noticeboard and in 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). All nursing staff had been trained to be a chaperone and had received criminal records bureau checks. We were told that reception staff were sometimes required to act as chaperone and there was a risk assessment in place regarding this. Although the risk assessment did not detail if staff would be left alone

with patients and reception staff had not received training in the role of a chaperone. Patients we spoke with had been offered a chaperone at times, although had not used the service.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators at both the practice and the branch surgery and found they were stored securely and were only accessible to authorised staff. The guidance for ensuring medicines were kept at the required temperatures was displayed on the fridge for easy access. This document described the action for staff to take in the event of the fridge going outside the required range. The policy was being followed by staff who checked the fridge temperatures. We saw records that confirmed the fridge temperatures were checked and recorded daily and recordings for the last six months showed they had remained within the required range of two and eight degrees centigrade.

Systems were in place to check medicines were within their expiry date and suitable for use. One member of staff checked these every month with records kept. All medicines we checked were within their expiry dates, although one emergency medicine was due to expire before the next check was due, showing improvements were required. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using current directions which were in line with legal requirements and national guidance. Training records showed that nurses had received appropriate training to administer vaccines. We looked at a sample of patient records and saw that vaccination batch numbers were recorded to ensure that if an alert was raised on the vaccine the practice could easily identify patients who had been affected.

There was a protocol for repeat prescribing which was in line with national guidance which GPs within the practice followed. One GP partner was the lead for monitoring prescribing and met with the CCG regularly to review prescribing within the practice and compare with other local practices. All prescriptions were reviewed and signed by a GP before they were given to the patient with systems in place to call patients in for regular medication reviews when required. Blank prescription pads were handled in accordance with national guidance, they were stored securely and records were kept of serial numbers of pads in use. GPs told us that they took prescription pads to home visits or wrote prescriptions when they returned to the practice. Patients could request repeat prescriptions online and in writing. Patients we spoke with said the repeat prescription process was convenient for them.

Cleanliness and infection control

We observed both the practice and the branch surgery to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw there were cleaning schedules in place and cleaning records were kept. A cleaner was employed at the practice five days a week. The cleaning at the branch surgery was carried out by contract cleaners twice each day. Annual audits were completed by the CCG infection control nurse with the last one in November 2014, the practice developed an action plan which included updating the cleaning schedule to detail the cleaning standards required. Staff told us they monitored cleanliness at the practice and branch surgery and reported issues to the practice manager who saw the cleaner daily.

One of the nurses was the infection control lead and they had undertaken training to enable them to provide advice on infection control.

All clinical and administrative staff received training about infection control specific to their role during their induction and completed regular updates, although the cleaner had not completed any infection control training. We saw evidence that the lead had carried out annual audits with the last one in September 2014 and an audit for hand washing in December 2014. The later involved both clinical and administrative staff, they watched a video, completed scenario exercises and used glow lotion and an ultra violet lamp to show how good individuals hand washing techniques were. Practice meeting minutes showed findings of these audits were discussed.

The practice used the CCG infection control policy which was dated 2005. Hand wash techniques were displayed in consultation rooms and toilets. Hand wash sinks with soap, gel and disposable hand towels were provided in consultation rooms. Clinical staff confirmed that they were responsible for cleaning between patients and we saw sufficient supplies in consultation rooms for them to do this. Personal protective equipment including gloves and

aprons were available to staff in consultation rooms and at reception should they be required. Spill packs were provided to deal with a range of accidents involving bodily fluids. There was a policy regarding needle stick injuries, dated 2011, which was displayed in consultation rooms. Suitable arrangements were in place for dealing with samples. All equipment used was disposable. General and clinical waste was stored separately at the practice and the branch surgery. Contracts were in place for the safe disposal of clinical waste. The practice had undertaken an audit of waste disposal in September 2014 which did not identify any issues.

The practice had completed a risk assessment regarding Legionella (a germ found in the environment which can contaminate water systems in buildings) in September 2014. This risk assessment did not identify any risks that needed action.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out their role including diagnostic examinations, assessments and treatments. We saw that all equipment was tested and had been calibrated in February 2015. All portable electrical equipment was routinely tested and displayed stickers indicated the last testing date. The fire alarm system was serviced annually.

Staffing and recruitment

The practice had a recruitment policy that clearly set out the process it followed when recruiting both clinical and non-clinical staff. Records we looked at confirmed that appropriate recruitment checks had been completed before new staff were employed. For example, proof of identification, references, qualifications, registration with the appropriate professional body and a Disclosure and Barring Service check being carried out for clinical staff.

We were told that staff levels were set according to workload with arrangements to prioritise tasks on a daily basis. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. The practice had carried out a telephone answering review, to monitor response time to ensure sufficient staff were available at key times. The practice used a formula based on the number of patients to determine the number of GPs they required.

Staff told us there were usually enough personnel 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 suitable arrangements to assess, manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building and equipment, risk assessments being completed and reviewed for fire safety and legionella, systems to monitor medicines and staff and policies and procedures to deal with a range of emergency situations. There was a health and safety policy and health and safety information was displayed at the practice and branch surgery for staff. The latest health and safety risk assessment identified only low level risks. Staff told us that risks were discussed at meetings and they were informed of how to respond to and minimise risk. Care plans for patients with long term conditions included information about what they should do if they were taken ill.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to deal with a range of different emergencies. The practice had a collapsed patient protocol which was reviewed annually and staff completed role play in how to respond. One of the GP partners was the lead for basic life support. Records showed all staff completed annual training in basic life support. Emergency equipment was available including oxygen at both the practice and the branch surgery. There was a defibrillator at the church immediately next door to the practice which staff at the practice could use and they had received training in how to use it. Emergency medicines were available at both the practice and the branch surgery and staff were aware of where these were kept. We saw emergency medicines were all within their expiry date, although as previously mentioned the system to check medicines needed improving to ensure it addressed any medicines due to go out of date before the next check.

A business continuity plan was in place to deal with a range of emergencies that might impact on the day to day operation of the practice including adverse weather, power failure and access to the building. The plan described

Good

Are services safe?

actions staff should take in certain eventualities and included the relevant contact details of contractors that may be required. We saw that the plan had been tested during the previous three months following a flood at the practice and on a separate occasion, the branch surgery not being accessible due to an incident in the local area. Staff described how they responded to both situations. Records showed these were recorded and the continuity plan was reviewed after each incident.

A fire risk assessment was carried out in September 2014 with no actions required. Fire drills were completed twice each year by the landlord and the practice carried out one each year. Panic alarms were in place in the event of an emergency, all staff spoken with were clear about the actions they needed to take if an alarm sounded and gave examples of incidents when they had been used and tested. The practice had a policy regarding dealing with patients who were abusive to staff which included sending a warning letter. Staff gave examples of an incident and the support the staff member was given and how this information was shared among staff.

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 approach to care and treatment prescribed which were in line with current best practice guidance. Systems were in place for updated information from the National Institute for Health and Care Excellence (NICE) and from local commissioners, although these systems did not include checking all staff were following updated guidelines. The practice followed the Clinical Commissioning Group (CCG) prescribing scheme and held quarterly meetings to discuss prescribing.

There were lead GPs for specialist clinical areas including diabetes, mental health, atrial fibrillation, heart failure and chronic obstructive pulmonary disease and the practice nurses supported this work. The practice identified at risk patients including those who attended hospital for the first time.

We saw the practice completed needs assessments and used templates to develop care plans. We reviewed a random sample of patient records and saw care plans were well documented. Patient notes were detailed, particularly for patients receiving end of life care and older patients. Data from the local CCG identified the practice's performance for emergency admissions were in line with local practices and antibacterial prescribing and non-steroidal anti-inflammatory medicines was above that of local practices. The practice was in line with the accident and emergency attendance rate across the CCG. All GPs we spoke with used national standards for referrals, patients with suspected cancers were referred to be seen within two weeks. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The practice achieved 98.7% of QOF points which was above the local area of 92.2% and the national average of 94.2%.

Interviews with GPs and nurses showed the culture in the practice was for patients to be referred on need and age, gender and race were not taken into account in this decision making, There was no evidence of discrimination with care and treatment decisions.

Management, monitoring and improving outcomes for people

All staff had key roles in monitoring and improving outcomes for patients. These roles included data input, calling patients for reviews and medicines management.

The practice had a system in place for completing clinical audit cycles. Individual clinicians presented their audit at clinical meetings to all clinical staff. We saw seven audits had been carried out during the last year including a completion of the cycle for atrial fibrillation which identified the practice had made good progress with complying with revised guidelines. We also saw a completion of the cycle for cholesterol management in patients with chronic disease, this audit identified an improvement in cholesterol levels which were above the target through a combination of use of the electronic patient records to flag patients, the recall systems in place, improved communication and education for patients. There was also a completion of the cycle of pregabalin in neuropathic pain. The audit identified that hospital consultants continue to initially prescribe the medication, the electronic patient record were coded correctly and improvements in the prescribing alternatives.

The practice used information collected for the QOF to monitor outcomes for patients. For example the number of patients with diabetes who had blood and foot checks were all above the national average. The number of patients with dementia who had received a face to face review in the last 12 months was 97% compared to the national average of 84%. Ninety one per cent of patients with mental health issues had a care plan, compared to the national average of 86%. The number of these patients with their smoking status recorded was at the national average of 95% and alcohol consumption was 92% which was above the national average of 89%. The practice was not an outlier for any QOF clinical targets and we saw patient outcomes were better or similar to those in other areas of the CCG.

The protocol for repeat prescribing was in line with national guidance. GPs reviewed repeat prescriptions and systems were in place to call patients for regular medication reviews.

Effective staffing

Practice staff included medical, nursing, administrative and managerial staff. We noted a good skill mix among the GPs, each with different areas of interest including diabetes, sexual health and contraception, diabetes, learning

Good

Are services effective?

(for example, treatment is effective)

disability, mental health and children's health. Systems were in place to ensure staff were up to date with mandatory training. The out of hours service covered the practice one afternoon a month to enable staff to attend training and development sessions. Staff training records showed all staff completed annual updates of basic life support training and had completed training in infection control and safeguarding. There was an induction programme for new staff. Staff who had been through the induction recently told us it gave them the information they needed to carry out their role. Staff we spoke with told us they had access to the training and support they needed to carry out their role.

Systems were in place for administrative staff to have an annual appraisal. GPs were up to date with their appraisal and had been revalidated or were working towards their 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).

The practice nurses were clear about the expectations of their duties and received training including: carrying out cervical screening; administration of immunisations and vaccines; spirometry; tissue viability; diabetes awareness and smoking cessation. Records confirmed nurses had an annual appraisal and nurses we spoke with told us they felt supported in their role. Regular nurses meetings were held with minutes taken that were made available to those unable to attend.

The practice is a training practice and had four doctors in training (two GP ST3, one GP ST1 and one F2 doctor). Those we spoke to said they had a good induction timetable and received the supervision and support they needed. There was a 'daily debrief' which all clinical staff used to discuss complex cases and check best practice guidance.

The practice had a policy to identify and deal with poor performance across the practice. The practice manager gave examples of how this policy had been used to improve performance.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage 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. All staff we spoke with were clear about their role in dealing with results and letters and felt the system worked. The practice had identified an issue with the system to alert patients to abnormal results in January 2015 and had taken appropriate steps to review patients and change the process to make it safe. We reviewed a sample of results and saw they were actioned appropriately.

The practice held multidisciplinary meetings every three months to discuss the needs of patients with complex health needs including those receiving end of life care, housebound patients and children on the at risk register. The palliative care meetings were attended by the palliative care nurse, district nurses, GPs, trainees and practice nurses. We joined one of these meetings for a short period and saw they were well organised and highlighted declining patients. Records showed when patients preferences were not achieved this was discussed and investigated. Health visitors were based in the same building and regularly attended clinical meetings, met with the safeguarding lead GP regularly and they told us they had an 'open door' policy for clinical staff to approach them. Health visitors said working relationships were good and gave examples of when they felt a child attending their appointment needed to see a GP urgently they would be seen by a GP. Midwives attended the practice once a week to provide shared care for pregnant women. The consultant paediatrician attended the practice every six to eight weeks. District nurses attended clinical meetings. We spoke with district nurses who felt the working relationship with the practice was good and that they had plenty of opportunities to discuss patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, information was received electronically and by post from out-of-hour and secondary care services. Referral letters were typed by doctors, and left for administrative staff to action. This system had been reviewed and improvements were planned to make the system safer.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care, all staff had received training on how to use the system.

Consent to care and treatment

GPs and nurses we spoke with were clear about the Children Acts 1989 and 2004 and the Mental Capacity Act 2015 and their duties to fulfil them. 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). 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 developing. These care plans were reviewed annually (or more frequently if required). We saw that 76% of patients with learning disabilities had care plans and 91% of patients with mental health.

Suitable arrangements were in place for seeking parental consent prior to childhood immunisations, clinical staff told us they sought verbal consent before carrying out an examination. Surgical procedures were not being undertaken at the time of our inspection.

Health promotion and prevention

Clinical staff demonstrated a good knowledge of the health needs of the local population and used this to determine health promotion. The nurses and health care assistant carried out NHS health checks and provided smoking cessation advice. The health care assistant and one of the nurses saw all new patients and took details of the individual and their family medical history including any health concerns and noted their smoking status. Any concerns were referred to the GP for follow up. There was a range of information leaflets available at the practice for patients to help them understand their condition and improve their health. The practice website contained information about common medical conditions. It also had information for pregnant women and new mothers. There was a range of information for young people on sexual health services, drugs, alcohol and mental health.

A member of staff was employed to provide health and well-being advice including a walking health promotion group. They also organised 'mindfulness' walks for new mothers.

The electronic recording system identified patients who required additional support, including patients with a learning disability, those receiving end of life care and patients who were carers. Records showed that 15 of the 21 patients on the learning disability register had received an annual health check so far this year. Systems were in place to ensure routine health checks were completed for patients with long-term conditions. Medicines reviews were completed annually. Forty eight per cent of patients in the at risk group had received the flu vaccination and 75% of people aged over 65 which was above the national average of 73%. Eighty one per cent of eligible women attended for a smear test which was just below the national average of 82%. There was a reminder system which included letters being sent to women who failed to attend their smear appointment.

Good

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 2014 national patient survey. Eighty nine per cent of respondents said they found receptionists helpful. Seventy one per cent of respondents said their overall experience at the practice was good or very good, this was below the CCG average and the practice were working to improve this and had introduced a triage system in the last year to enable patients better access to GPs when required. Ninety one per cent of respondents said the last nurse they saw was good at treating them with care and concern which was above the national average 85%. The practice patient survey 2015 identified that most patients found reception staff helpful and that it was easy to speak with reception staff over the phone. Patients said they generally waited 5-10 days for an appointment with their usual GP, most patients said they could see any GP urgently on the same day. Most patients understood the appointment system, the referral system, they were satisfied with the care they received and were aware how to make a complaint.

Patients we spoke with said staff were polite and respectful. They said their privacy was maintained during appointments because consultation room doors were closed.

We saw staff spoke to patients politely. There was a screen at reception and chairs in the waiting area were clustered away from the reception desk to help maintain privacy. Information regarding chaperones was displayed in consultation rooms. Some patients we spoke with had been offered a chaperone, although had refused the offer.

We saw that consultations took place in rooms with the door closed. Disposable curtains were provided in consultation rooms to provide privacy during examinations. Clinical staff we spoke with were clear about how they maintained patient's privacy and dignity. Records were stored securely.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that they were involved in making decisions about their care and treatment. According to the National GP survey 78% of respondents said that the last GP they saw or spoke to was good at involving them in decisions which was just below the national average at 81%. Eighty one per cent of patients said nurses were good at involving them in decisions which was in line with the national average. Figures were above the national average for the number of patients who said clinical staff were good at giving them enough time.

Staff told us that they had access to translation services; they said there had been issues with access to the service recently, although they were not able to identify patients who had not received appropriate care and treatment because of this. Staff said if patients bought a relative to interpret they assessed whether this was appropriate.

There was a range of information leaflets about different long term health conditions and maintaining a healthy lifestyle in the waiting area for patients to read and take away. The Patient Participation Group met every other month, these meetings had included talks from external speakers about a range of long term health conditions with information about how patients could look after themselves.

Patient/carer support to cope emotionally with care and treatment

Patients and carers had access to a range of leaflets in the waiting area relating to support services available in the local area to meet their various needs. The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 88% of respondents to the national GP survey said the GP was good at listening to them and 80% said the nurse was good at listening to them.

Staff told us that when families suffered a bereavement, they decided who was the best person to contact them to offer support and provide information or direct them to information they needed. The palliative care nurse confirmed the end of life care provided by the practice included ensuring carers and family members received the support they needed.

Clinical staff gave examples of the local services they signpost patients who were carers to for support and information. We saw electronic patient notes included details of information given to carers during routine appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the local population were well known and understood and the practice was responsive to those needs. Staff demonstrated a good knowledge of patients and how best to meet their needs. One of the GPs met with the Clinical Commissioning Group (CCG) every month. These meetings were used to identify where practices in the area needed to make improvements to meet patient needs. For example the provision of the elderly care nurse who supported housebound patients to remain at home and avoid unnecessary hospital admission.

A Patient Participation Group (PPG) was set up in 2006 and this group continue to meet six times a year. They had 40 members with around 10 regular attendees. The practice had identified that the group were not fully reflective of the younger patient population group and were actively trying to seek new members by advertising and changing the times of the meetings to enable working age people to attend. The PPG were involved in developing and analysing practice patient surveys and developing action plans to make suggested improvements. We were told improvements made included changes to the appointment system, provision of 'catch up' slots to reduce the time patients waited when attending for an appointment and improvements to patient privacy at reception.

Tackling inequity and promoting equality

The practice recognised the needs of different groups when planning services. For example, they provided longer appointments for people with long term conditions, learning disabilities and when patients needed an interpreter. They had a specialist nurse co-ordinator for older people who carried out home visits for patients who were housebound. The electronic patient record had a system to identify patients whose circumstances made them vulnerable. We were told that there were systems to enable patients who were homeless to register at the practice.

The practice had access to online and telephone translation services. Information displayed for patients was mainly in English, the electronic sign in system was only in English.

The practice was situated on the ground floor, the reception desk included a low section suitable for people who used wheelchairs and all consultation and treatment rooms accessible to people with disabilities. The waiting areas were large enough to accommodate patients with wheelchairs and prams. Accessible toilets were available. The branch surgery was purpose built, located on the ground floor and accessible for people with disabilities.

Access to the service

The practice was open five days a week from 8.00am-6.30pm Monday to Friday. Appointments were provided from 9.00am-12noon and 3.00pm-5.30pm with extended hours on Tuesday and Wednesday from 6.30-8.00pm at the branch surgery. When the practice was closed, the answer machine message directed patients to contact the out of hours provider. The CCG provided funding for the out of hours service to provide cover one afternoon a month to enable all staff to attend training sessions.

There were a range of book in advance and appointments for on the day emergencies which the GPs triaged to ensure patients who needed to see a GP were offered an appointment. Appointments outside of school hours were available for children and outside of office hours for working age patients and students. Telephone consultations were not bookable, although patients could request a GP to call them back over the next couple of days. Home visits were carried out when patients were too ill to attend the practice and for housebound patients. Longer appointments were made available when required. Reception staff were clear about the procedures that required a longer appointment. Appointments were bookable in person, on the telephone and patients could book on-line. We were told that additional book on the day appointments were provided on the day after a Bank Holiday to meet increased demand. On the day of inspection there were still 10 emergency appointments available for afternoon and evening surgery. The routine advance appointment for a chosen GP had an approximate two week wait. Reception staff reported that the text message system had helped reduce the number of missed appointments. This system was publicised in the practice newsletter.

Patients we spoke with were happy with the system for emergency appointments, confirming they could see a GP on the day or the next morning when necessary. However,

Good

Are services responsive to people's needs?

(for example, to feedback?)

they were not satisfied with the wait for a routine appointment to see a GP of their choice. The responses to the national GP survey showed 61% of patients described their experience of making an appointment was good which was slightly below the CCG average 69%. The practice had reviewed the appointment system and made changes which were to be reviewed. Eighty one per cent of respondents said they were able to get an appointment the last time they tried. Sixty per cent of respondents with a preferred GP said they usually get to speak to that GP which was above the CCG average of 53%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the practice. Arrangements were in place for the assistant practice manager to support the practice manager with this role to ensure there was always someone available to deal with complaints.

We saw information was available to help patients understand how to make a complaint. This was displayed in the waiting area and included on the practice website. Patients we spoke with were aware of the process to follow if they needed to make a complaint, although they had not needed to.

We looked at 15 complaints received in the last 12 months. All had been acknowledged, investigated and the patient responded too in a timely manner in line with the policy. Responses to patients showed apologies were made. We saw that complaints were discussed and learning was shared with staff at meetings.

The practice reviewed complaints annually to identify any trends. We looked at the report for the last year and found there were no themes; however lessons learned from individual complaints had been acted upon.

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 provide a high quality service. They aimed to do this by involving patients, promoting good health, working with other health and social care providers, to involve patients in the practice through the Patient Participation Group (PPG) and ensured staff had the right skills, training and development to carry out their role. The values were part of the business plan. Staff told us they felt involved in the practice and were aware of the strategy and vision. They said that they worked with other health care professionals to help patients manage and improve their health conditions. Staff said they received the training and support they needed.

Governance arrangements

There was a clear leadership structure. The partners each had an area of responsibility. There were named staff in lead roles for safeguarding, infection control, health and safety, links with the Clinical Commissioning Group and medicines management. Staff we spoke with in these roles were aware of their responsibilities. All staff we spoke with were aware of the leads for these roles. Staff were aware who to report issues and concerns to. The practice had the required policies and procedures which were being reviewed and updated. There was a business continuity plan which detailed actions to be taken in the event of a range of situations including flood and power failure which could affect the operation of the service. The GPs and staff we spoke with were aware of the arrangements in place and described how they responded to recent incidents when the plan was put into action. Systems were in place to identify, record and manage risks. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data showed the practice was performing above and in line with local and national standards. We saw the QOF data was discussed at meetings and action plans were produced to maintain or improve outcomes for patients.

Leadership, openness and transparency

We saw from minutes that a range of meetings were held regularly. Staff told us they had opportunities to make suggestions and raise issues at meetings. Staff told us the GP partners were approachable and available to provide support, guidance and information when required.

There was a range of human resource policies and procedures including induction, disciplinary and sickness policies. The practice manager was responsible for human resources. Policies were accessible to staff in a shared folder on the electronic recording system.

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

The practice gathered feedback from patients through annual patient surveys, the PPG, the Friends and Family Test and complaints and compliments received. The PPG was set up in 2006, they met six times a year and were involved in seeking patient feedback, analysing responses and developing action plans to improve patient experience. Improvements initiated by the PPG have included staff training to ensure patients privacy was maintained at reception and a review of the appointment system which led to the triage system currently in place.

Staff we spoke with told us they had opportunities to voice their opinions at staff meetings, discussion and during appraisals. Staff felt confident that their views would be listened to.

There was a whistleblowing policy and staff we spoke with were aware of this policy and where they could access it.

Management lead through learning and improvement

Staff told us that they were supported to continue their learning and attend relevant and regular training updates. Records showed that all administrative and nursing staff had an annual appraisal.

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed records of significant events which showed the practice learned from incidents, action plans were developed to minimise risk of recurrence and relevant staff were informed of the findings.

A range of regular meetings were held including a weekly clinical meeting for GPs and nurses which were recorded and minutes made available for those unable to attend. Team leaders and nurses met every month and there were quarterly practice meetings. The partners met regularly.

The practice had recently been re-accredited as a training practice, three of the GPs were trainers and three trainees were at the practice at the time of our visit.