

Dr Ramesh Sharma

Quality Report

Borough Medical Centre, Lornamead House
1-5 Newington Causeway
London
SE1 6ED
Tel: 020 7357 7852
[www.drsharma-boroughmedicalcentre.nhs.uk/
the-practice](http://www.drsharma-boroughmedicalcentre.nhs.uk/the-practice)

Date of inspection visit: 22 April 2015
Date of publication: 12/06/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8

Detailed findings from this inspection

Our inspection team	9
Background to Dr Ramesh Sharma	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	11
Action we have told the provider to take	25

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Ramesh Sharma on 22 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. However we found the practice to require improvement for providing safe care. Staff did not have training in chaperoning, fire safety and the practice nurse's basic life support refresher training had expired. We found that the practice had not protected people against the risk of the spread of, infections, including those that are health care associated.

It was also good for providing services for older people, people with long term conditions; mothers, babies, children and young people; the working age population and those recently retired.; people in vulnerable circumstances and people experiencing poor mental health .

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.

Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Action the provider MUST take to improve:

- Must take action to address identified concerns with infection prevention and control practice. Including ensuring COSHH guidance is followed for the disposal of cytotoxic clinical waste.
- Must take action to ensure staff have updated training in basic life support, chaperoning and Fire training.

Action the provider SHOULD take to improve:

- Ensure they develop a business plan to govern activity.
- Ensure clear responsibilities of repairing and cleaning of the premises are in place and agreed with the other practice they share facilities with.

-

Ensure they appoint an infection control lead to support staff in infection control practices within the 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 providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However we found that the practice had not protected people against the risk of the spread of, infections, including those that are health care associated. Staff had not undertaken training in fire safety and chaperoning. The practice nurse had not renewed their basic life support training.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff communicated and worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information

Good



Summary of findings

about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evident.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. 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. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Good



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 provider was rated as good.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The provider was rated as good

Longer appointments and home visits were available when needed. All patients with long-term conditions had a named GP and a structured annual review to check that 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 provider was rated as good

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

The provider was rated as good.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the

Good



Summary of findings

services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The provider was rated as good.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for patients with a learning disability and 95% of these patients had received a follow-up. Longer appointments were offered to patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

The practice had a counsellor on site who saw patients that needed support at the practice.

Good



People experiencing poor mental health (including people with dementia)

The provider was rated as good

All patients registered at the practice experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We spoke with ten patients during our inspection and received 38 completed comments cards.

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.

The patients we spoke with had not made a complaint; however, they were aware of the process and said they would speak with the staff and felt confident that their issues would be addressed.

Patients said they were treated appropriately and staff maintained their privacy and dignity. We observed staff speaking politely to patients. Patients said they were involved in decisions about their care and treatment.

The 2013/14 GP survey results (latest results published in Jan 2015; 428 surveys were sent out, with 78 returned giving a 18% completion rate) showed 84% of respondents said the last GP they saw or spoke to was good at listening to them and 78% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. 83% of the respondents said the last appointment they were given was convenient and 87% found the receptionists at the surgery helpful.

Areas for improvement

Action the service **MUST** take to improve

- **Must take action to address identified concerns with infection prevention and control practice. Including ensuring COSHH guidance is followed for the disposal of cytotoxic clinical waste.**
- **Must take action to ensure staff have updated training in basic life support, chaperoning and Fire training.**

Action the service **SHOULD** take to improve

- **Ensure they develop a business plan to govern activity.**
- **Ensure clear responsibilities of repairing and cleaning of the premises are in place and agreed with the other practice they share facilities with.**
- **Ensure they appoint an infection control lead to support staff in infection control practices within the practice.**

Dr Ramesh Sharma

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP specialist advisor and a nurse advisor. They are granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Dr Ramesh Sharma

The surgery is located in the London Borough of Southwark, and provides a general practice service to around 2,000 patients. The ethnicity of patients is mainly those of Asian and Black Caribbean with a number of white British patients. The practice has a high number of young students as it is located in the Southbank university area with a small number of patients aged 65 and over.

The practice is located in a purpose built building and shares facilities with another GP practice and primary care services.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; family planning; and maternity and midwifery services at one location.

The practice has a General Medical Services (GMS) contract and provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, contraception services and minor surgery. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is currently open five days a week from 8:00am - 18:30pm. In addition, the practice offers extended opening hours from 6:30 pm to 7:00pm on Mondays and Thursdays. Consultation times are 08:00am until 13:00pm and 16:00am until 18:30pm.

The practice had opted out of providing out of hours (OOH) services to their own patients and directs patients to the out-of-hours provider SELDOC. The practice was also taking part in a local initiative for the Clinical Commissioning Group (CCG) where extended hours were being offered daily at one practice in the locality and all patient records registered in the CCG were available through the electronic system.

The practice has a single handed male GP, a female practice nurse working eight hours per week, two administrative staff and a counsellor who is at the practice once a week. The practice manager was based at the practice one day a week. We were told by the GP and practice manager that Southwark CCG had reduced the funding for practice manager posts in 2012. As a result most practices had formed alliances locally to employ a practice manager that worked across different sites. The practice manager therefore worked across three other practices.

There were no previous performance issues or concerns about this practice prior to our inspection.

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.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

- Working age people (including those recently retired and students)
- People 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 a range of 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 and reviewed the personal care or treatment records of patients. We received 38 completed comment cards where patients and members of the public shared their views and experiences of the service.

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. These included for example, 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.

We reviewed the safety records, incident reports and internal communications for the last 12 month period. These showed the practice had managed these consistently over time and so could evidence a safe track record over this period.

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 12 months and these were made available to us. The practice used a reporting system that was monitored by the Clinical Commissioning Group (CCG). The process involved completing an online incident report record. The practice had their own internal system of monitoring and analysing incidents to ensure any shortfalls were immediately rectified. There was evidence that appropriate learning had taken place and that the findings were shared with relevant staff.

All staff were aware of the system for raising issues to be considered for discussion at the practice and felt encouraged to do so. All staff we spoke with told us that incidents were reported to the practice manager as soon as possible and a written account of the incident was recorded on the electronic reporting system. Examples of incidents that we noted included a request received by the practice to remove a deceased patient from their records. The practice had not been notified that the patient had died and might have continued to send appointment letters to them. Following this incident the practice communicated the error to the local hospital and we noted that the hospital had written to the practice reassuring them of how they were improving their death notifications in future to avoid similar errors for re-occurring.

National patient safety alerts were disseminated by the practice manager to practice staff. We saw examples of when alerts had been received and appropriate action had been taken. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for such as changes in childhood vaccination schedules and withdrawal of some medicines used in long term care.

Reliable safety systems and processes including safeguarding

The practice had policies in place relating to the safeguarding of vulnerable adults, child protection and whistleblowing. The GP was the designated lead for safeguarding at the practice. Staff we spoke with were aware of their duty to report any potential abuse or neglect issues. The GP and the nurse had completed Level 3 and 2 child protection training respectively. The training was due for renewal at the end of May 2015 and we saw records that confirmed the training sessions that had been booked. Reception staff had received Level 1 training. Staff had also received training in safeguarding of vulnerable adults and clinical staff all had a criminal records check DBS (now the Disclosure and Barring Service). The contact details of the local area's child protection and adults safeguarding departments were accessible to staff if they needed to contact someone to share their concerns about children or adults at risk.

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 such as those for Looked After Children (LAC) and those on protection plans who required additional monitoring.

A chaperone policy was in place and on display 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 professionals during a medical examination or procedure). No chaperone training had been undertaken by staff. However they were able to talk us through the role of being a chaperone. The practice manager was aware of the need for staff to have chaperone training. Records we were shown confirmed that in house training had been sourced and was due to be delivered to the practice in May 2015. All staff acting as chaperones had been DBS checked.

Are services safe?

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. This system was widely used throughout the CCG and so patient information was widely accessible to all practices including those offering extended hours services for the whole CCG.

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

The practice had procedures in place to support the safe management of medicines. Medicines and vaccines were safely stored, suitably recorded and disposed of in accordance with recommended guidelines. We checked the emergency medicines kit and found that all medicines were in date. The vaccines were stored in suitable fridges at the practice and the practice maintained a log of temperature checks on the fridge. Records showed all recorded temperatures were within the correct range and all vaccines were within their expiry date. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably. No Controlled Drugs were kept on site.

The GP followed national guidelines and accepted protocols for repeat prescribing. All scripts were reviewed and signed by the GP and the GP specialist adviser in our inspection team found these acceptable. The nurse administered vaccines 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 nurse had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. However we noted that the not all chairs in the patient waiting area had plastic covers to enable cleaning and reduce the risk of cross infection. The practice manager advised that they had noted this in their practice risk log and were in the process of discussing the associated costs as the waiting room was shared with another practice.

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. However the schedule was not completed consistently. The cleaning schedule had last been completed in February 2015. No system was in place for the practice to reassure themselves that the cleaner was carrying out the required cleaning duties. The cleaning duties for the building were undertaken by one company for the practice and another practice in the building. From our discussions with staff the role of ensuring the cleaning was taking place had not been fully discussed between the practices and so was unclear.

The practice had a system for the safe disposal of sharps and clinical waste. However we noted that for the disposal of sharps used for cytotoxic injections; purple lidded sharps bins were not used as recommended, instead the practice used yellow lidded bins. This was not in line with the policy for the control of substances hazardous to health (COSHH). The practice manager advised us that they had not been made aware of this shortfall and the CCG infection control team had not identified this in their audits. However they would be ensuring the appropriate bins for disposal were ordered.

All staff had received induction training about infection control specific to their role and thereafter annual updates from the date of the last training. The practice had not appointed a lead person for infection control but sought advice and guidance from the CCG infection controls nurses. The CCG infection control team had conducted an infection control in the last 12 months and we saw an action plan and changes that had been implemented following this audit.

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. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that

Are services safe?

confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence that calibration of relevant equipment had been completed in November 2014.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. For example the practice nurse was contracted to work once a week, but there were arrangements in place for her to attend more sessions if required to meet patient needs. There was also an arrangement in place for administrative staff, to cover each other's annual leave and sickness.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. 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. Fire and building checks were completed on a yearly basis. However the practice did not have an identified health and safety representative and staff had not undertaken fire safety training. Although staff had not had the required training, on the day of the inspection we found evidence that the training had been sourced and booked to be delivered to staff in May 2015. The practice manager was aware of the

need to have a health and safety lead. However discussions were still to be held with the other practice located on the same site as it was unclear whether this needed to be a shared responsibility.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at CCG level and the practice had internal systems of communicating identified risks to staff. For example, the practice manager had shared the findings from an infection control audit with the team and all staff had been involved in the process of identifying action to take. The practice had also identified the risk of being a single handed practice. As such they had identified the need to develop a locum pack that was useful for locum staff should there be need to cover in the absence of the GP. This pack gave clear instructions on systems in place including information on CCG directives and referral pathways.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that most staff had received training in basic life support. However the practice nurse was a month overdue in attending a refresher update. We were shown records that confirmed the training had been booked for the beginning of May 2015. 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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. 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

Are services safe?

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 if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. However records showed that staff were not up to date with fire training and no regular fire drills were practised.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and practice nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw records confirming guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and nurse that staff completed thorough assessments of patients' needs in line with NICE and CCG guidelines and these were reviewed when appropriate.

The GP told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions.

The GP showed us data from the local CCG of the practice's performance for prescribing and monitoring of conditions, which were comparable to similar practices. The practice had also completed a review of case notes for patients with diabetes which showed all were receiving appropriate treatment and regular reviews. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two days by the GP according to need.

National data and our intelligence monitoring information showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The practice used a local pathway for patient referrals that was monitored by the CCG.

Discrimination was avoided when making care and treatment decisions. The interview with the GP showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

The GP showed us three clinical audits that had been completed between April and December 2014 as part of the local CCG initiatives. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example an audit had been completed to assess the cost effectiveness of Pregabalin in Neuropathic Pain management. Pregabalin was licensed for use in neuropathic pain, although it was not the most cost-effective drug to prescribe for neuropathic pain when compared to the other NICE recommended treatment options such as gabapentin. The practice identified that it had four patients who had been prescribed pregabalin. The practice developed treatment plans with active switching to an alternative first line therapy in those patients whose pain had not been adequately managed with pregabalin. These patients were monitored over a three month period, with regular clinical reviews over a that period. On follow up the practice found that the condition was much better managed on the alternative medicine. The practice had plans to re-audit the management of these patients again in one year.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the quality of repeat prescribing policies and systems within Southwark. The audit confirmed that the practice was adhering to its Repeat Prescribing Policy and there were no significant issues highlighted by the audit.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For

Are services effective?

(for example, treatment is effective)

example, 94% 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).

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GP 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 GP had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example prescribing for antibiotics and Non-Steroidal Anti-Inflammatory drugs was similar to expected.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as safeguarding training and information governance. The GP was up to date with their yearly continuing professional development requirements and had been revalidated in 2014. (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 had records showing the practice nurses' registration with the Nursing and Midwifery Council (NMC) was current. The practice had also verified these records.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. The CCG had introduced a system for all practice nurses to

be appraised by a senior clinical lead for the CCG. The practice was still waiting for this to take place and had been in touch with the responsible person to arrange suitable dates.

Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, such as travel vaccines and customer service training. They held in-house training days where trainers attended.

The practice nurse had defined duties they were expected to perform working alongside the GP. Their training records demonstrated they were trained to fulfil these duties. For example, they had received training in administration of vaccines, and in performing cervical cytology.

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, and communications from the 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 reading, passing on and actioning any issues arising from communications with other care providers on the day they were received. The GP was fully responsible for all the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook continuous audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed. The practice monitored the unplanned admissions into hospital for older patients and those with long term conditions. All patients on this register had been risk stratified and all patients identified had a care plan. The practice also used a risk profiling template designed by the CCG to monitor care and improve outcomes.

Are services effective?

(for example, treatment is effective)

The practice held quarterly multidisciplinary team meetings and communicated well with district nurses and health visitors. The practice had no patients on the palliative care register and so the palliative care team was not involved.

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. For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. The GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice also had signed up to the electronic Summary Care Record and had plans to have this fully operational by the end of 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff 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.

Consent to care and treatment

We found that clinical staff were aware of the requirements of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. The GP understood the key parts of the legislation and was 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. Ten clinical notes we reviewed confirmed this. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear

understanding of Gillick competencies. (The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.)

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse though not mandatory. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GP to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 100% had a completed physical health check in the past year.

The practice also had systems for identifying 'at risk' groups so that they could offer additional support. For example, the practice aimed to follow up people who had been discharged from hospital within two days and practice records showed that this system had been successfully completed for 100% of people.

The practice's performance for cervical smear uptake was 74% for the 2013 /2014 period which was above other practices in the CCG. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The nurse was responsible for following-up patients who did not attend screening.

National screening for bowel cancer and breast cancer was managed by the local hospitals. The practice worked with the hospitals to send reminder letters to patients who failed to attend screening appointments and non-responders.

The practice offered a full range of immunisations for children, adults and travel, in line with current national guidance. The practice's performance on childhood immunisations during the 2013/2014 period, for children aged three months to 12 months were as follows; Dtap/IPV/ Hib (Diphtheria, Tetanus, acellular pertussis (whooping cough), poliomyelitis and Hemophilus influenza type b)

Are services effective?

(for example, treatment is effective)

100%, Meningitis C and PCV (Pneumococcal conjugate vaccine) 75% and MMR (measles, mumps, and rubella) 95%; all were above the CCG average. The practice had a clear policy for following up non-attenders by the practice nurse and GP. We saw records that confirmed this was

being followed. The practice were also aware that a number of their patients with children were highly mobile with others moving from abroad and as such some of their rates were lower due to this.

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. The 2013/14 GP survey results (latest results published in January 2015; 428 surveys were sent out, with 78 returned giving a 18% completion rate) showed 84% of respondents said the last GP they saw or spoke to was good at listening to them and 78% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. Eighty three percent of the respondents said the last appointment they got was convenient and 87% found the receptionists at the surgery helpful.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 38 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All the patients we spoke with 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 to maintain confidentiality. The practice switchboard was located away from the reception which helped keep patient information private. Only one patient was allowed to approach the reception desk at any given time. 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.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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 2013/2014 national patient survey showed 72 % of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

Patients we spoke with 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 areas informing patients this service was available through the telephone system or face to face.

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement received a phone call by the GP. This call was either followed by a consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke had not needed this support but were aware that bereavement support was available if needed.

Are services caring?

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations such as the housing team or the citizen's advice bureau. The practice's computer system alerted the GP 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.

During patient registration the practice noted down details of carers. This was to ensure they were offered support and information. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice had the services of a counsellor who was employed by the CCG. Sessions were held once a week at the practice and the GP was able to directly refer patients and reduce waiting times.

The practice was also working in partnership with the CCG and Southwark Carers to provide an afternoon clinic once a month hosted by a representative from Southwark Carers to provide information about what support was available and information on how to access benefits and respite for carers.

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 patient'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 in the way services were delivered.

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings and communications where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population such as developing a new healthy weight service for patients who struggled with losing and keeping a healthy weight.

Longer appointments were made available for patients who needed them. We saw notes on the electronic system that informed staff booking appointments if longer appointments were needed.

Home visits were made to those patients who were too ill to attend the practice or those with mobility difficulties. The GP told us that they carried out one to two home visits per week or as needed.

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. For example students attending the local university, homeless people and asylum seekers. As a result the practice recognised the need to support students to register easily with the practice during term time and also worked closely with organisations such as housing. The practice offered patient registrations and

opportunistic appointments to homeless patients. They also had a system in place for flagging these patients. Staff told us that they prioritised appointments for vulnerable patients to reduce the likelihood of a missed opportunity in providing them access to healthcare.

The practice proactively followed up on children who missed their childhood immunisations and GP appointments and this information was passed to the relevant local teams including searching and passing on information to other health organisations where people had moved.

The practice offered emergency appointments to school age children at times that were suitable. A new service had also been started within the CCG at a local surgery that was offering more enhanced hours. Staff were directing patients to this service.

The practice had access to online and telephone translation services for patients who spoke other languages.

The practice provided equality and diversity training to staff 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 8:00am - 18:30pm. In addition, the practice offered extended opening hours from 6:30 pm to 7:00pm on Mondays and Thursdays. The practice was also taking part in a local initiative for the CCG where extended hours were being offered daily at one practice within the locality. These appointments were particularly useful to patients with work commitments.

Comprehensive information was available to patients about appointments on the practice website. This included how to get help in an emergency, requests for home visits, getting test results, changing address, accessing medical records and how to book and cancel appointments through the website. Information was also available on the various services available at the practice. There were 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

Are services responsive to people's needs?

(for example, to feedback?)

an answerphone message giving the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Patients were 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.

The practice was on the ground floor. 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.

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 and the practice manager was the designated responsible person who handled all complaints at the practice.

We saw that information was available to help patients understand the complaints system. This was included in the practice information leaflet and displayed in the reception area and on the practice website. Patients we

spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the record of complaints and found that two formal complaints had been received in the last 12 months. All complaints had been dealt with in a timely manner and had been resolved. A number of actions were taken by the practice manager and clinicians to improve the quality of the service in response to any complaints. For example, the practice manager had convened meetings with clinicians and administrative staff to discuss a complaint that was relevant to them.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review in 2014 and found that lessons learnt from individual complaints had been acted upon. The practice welcomed comments from patients. These were via a suggestion box. Staff told us this was checked monthly and common themes were fed back in meetings and through communications with staff.

The practice had an active Patient Participation Group (PPG). We met with two representatives from the PPG during our inspection. They told us they met regularly and were consulted about the smooth running of the practice. We saw minutes from a meeting where the results from the annual patient survey were discussed in order to identify strategies for improvement

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 did not have a strategy or business plan in place to detail its vision but the practice vision was detailed in the statement of purpose. The practice vision was to deliver high quality care and promote good outcomes for patients. We did not see the vision displayed in staff rooms but all four members of staff we spoke with understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice had a handbook for staff that was given to them when they first joined the practice. Staff were required to sign a record confirming they had read and understood the policies. The practice manager explained that when policies were changed or updated it was communicated to staff via email and in meetings. Records we reviewed confirmed this.

We looked at 10 of these policies and procedures. All 10 policies and procedures we looked at had been reviewed three yearly as per governance policy and were up to date. The practice also used policies devised by the CCG and also had systems to ensure the policies were adaptable to their practice.

Due to the practice being a single handed practice it was clear that the GP was the lead. The practice manager worked once a week from the practice. During his absence staff were available to contact the practice manager from another site they worked from and also sought guidance from the GP. We were told by both the GP and practice manager that due to changes with the CCG funding in Southwark, most practices had not been able to employ practice managers working on a more full time basis. Instead a group of practices had teamed up and shared a practice manager working across sites. Staff we spoke with told us that this arrangement worked well with them as a small team. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We found from our discussions with staff that the practice had not clearly put in place arrangements with another

practice they shared facilities with to have clear accountability on the management of areas such as building facilities. The premises were cleaned by a shared company and no one at the practices had taken the responsibility to ensure that the cleaning schedule was checked. Building fire checks were not being carried out and the practice was unsure about who would take responsibility for these checks.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for the practice showed it was performing in line with national standards. For the period 2013/2014 the practice had achieved 887 points out of 900; score of 98%. The practice manager was previously employed by the CCG when QOF was first introduced. As a result they had transferable experience that was used by the practice to improve outcomes for patients and ensure that the practice was working towards all the identified requirements. The GP showed us templates that were used in the CCG to ensure "every contact counted". The GP also attended meetings held by the CCG to ensure all practices were working within the identified needs and improvements were made in those areas that were performing less well.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Examples of completed clinical audits included cost effective prescribing and an audit on the prescribing of the practice.

The practice had arrangements for identifying, recording and managing risks. The practice had identified that by having a single GP, there might have been instances when the GP was off sick or had to take planned holidays. As a result the practice had developed a comprehensive locum pack that gave directives on how the practice operated.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues during one to one sessions or meetings. The practice manager told us that due to the small number of staff they had, no team away days were planned for business continuity purposes but day to day communications were used to address any issues. Our

Are services well-led?

Good 

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

discussions with staff found that as much as the practice manager was not at the practice daily the GP was supportive and they had access to contact the practice manager from the other locations they worked from.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as staff induction and absence and 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 and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups; such as students, the elderly and the Asian community. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The practice had recently introduced the Family and Friends Test (FFT) and were in the process of analysing their results. The practice also asked patients to complete surveys through the practice website which they used to improve accessibility.

The practice had gathered feedback from staff through 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 whistleblowing 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. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. However the CCG had identified the need for the practice nurse to be appraised by a clinical lead within the CCG. This had not taken place as yet but records we saw confirmed that the practice had made all efforts to arrange for this.

The practice had completed reviews of significant events and other incidents and shared with staff to ensure the practice improved outcomes for patients. An example for this was a complaint from a patient where they felt the booked appointment had not allowed them enough time to explore all their concerns with the GP. Following this incident the practice had placed alerts on patient records to ensure reception staff booked double appointments where required or during that first call asked patients if they had a number of concerns to ensure an adequate appointment was booked.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	Regulation 12 HSCA (Regulated Activities) Regulations 2014 Regulation 12: Safe care and treatment
Maternity and midwifery services	12.
Surgical procedures	2(c) We found that the practice was not ensuring that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely;
Treatment of disease, disorder or injury	Staff had not undertaken fire safety training.
	Basic Life Support training was overdue for staff
	Staff had not undertaken formal Chaperoning training
	12
	2(h) We found that the practice had not protected people against the risk of the spread of, infections, including those that are health care associated.
	The practice did not have systems in place to monitor the cleaning schedules.
	The chairs used in the patient waiting area were not suitable as they could not be easily wiped and posed a risk of cross infection.
	The practice did not follow COSHH guidance to dispose of cytotoxic injections.