Care Quality Commission

Rushey Green Group Practice

Quality Report

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

Contents

Summary of this inspection	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8
Outstanding practice	8
Detailed findings from this inspection	
Our inspection team	9
Background to Rushey Green Group Practice	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	27

Summary of findings

Overall summary

Rushey Green Group Practice provides GP primary care services to people living in the borough of Lewisham and is a GP training practice. It has just over 12000 patients registered.

During our visit , we spoke with the GPs, the deputy practice manager, nurses, health care assistant (HCA) and administrative staff. We spoke with eight patients and a representative of the practice's patient participation group (PPG). Sixteen patients completed comments cards telling us what they thought of the care they had received from the service.

All the patients were satisfied with the quality of care and support offered by the surgery. The practice had an active patient participation group (PPG) that met bi-monthly and contributed to the annual patient surveys which were carried out.

The practice had a clear vision statement and an accessible leadership team. Staff told us the practice had a supportive open culture and were fully aware of the governance arrangements in place. Staff were well supported in their work and were given protected time for mandatory training each year.

There were processes in place to report significant events and any incidents that occurred at the practice. We saw evidence of learning from incidents and appropriate safeguarding policies and procedures were in place.

Treatment was delivered in line with recognised national guidance including the National Institute for Health and Care Excellence (NICE) and they participated in clinical audits and peer reviews.

The practice demonstrated an understanding of the needs of the local population. However, we found improvements were required to ensure the practice is more responsive to people's needs, as patients told us they found it extremely difficult to get an appointment at the surgery.

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 provided safe care to patients by assessing risks and minimising their impact. There were processes in place to report significant events and any incidents that occurred at the practice. There was evidence of learning from incidents and the necessary changes made to policies and procedures

The practice had a risk identification and assessment tool which was completed annually. Risks to clinical practice, the computer systems, staff and premises were identified and steps taken to control them. Appropriate arrangements were in place to deal with both clinical and non-clinical emergencies.

Appropriate safeguarding policies and procedures were in place and all staff had received safeguarding training for children and adults. Appropriate criminal records checks were carried out for clinical staff and there was a risk assessment process in place for non-clinical staff. However, the practice had not carried out criminal records checks on non-clinical staff who acted as chaperones.

The practice had effective systems to ensure that people who used the service were not harmed as a result of unsafe equipment. Whilst the practice was clean on the day of our inspection, no infection control audit had been completed since 2010.

The practice did not have a defibrillator and had not carried out a risk assessment regarding responding to emergencies.

Are services effective?

Treatment was delivered in line with recognised national guidance including National Institute for Health and Care Excellence (NICE) and best practice.

Patient outcomes were monitored as the practice participated in clinical audits and peer reviews. At the time of our inspection they were participating in a study which was comparing hospital referral rates for GP's in Lewisham in the areas of dermatology, gynaecology, ENT and gastroenterology.

Staff were well supported in their work. They received a formal induction, had regular opportunities to discuss their work and there was an appraisal system in place.

The practice had close working relationships with other health and social care professionals such as health visitors and the local community mental health team.

Summary of findings

The practice provided additional services such as an asthma clinic, child health and development clinics, drug and alcohol services, counselling (adult's children and young people) and minor surgery. They provided a smoking cessation clinic however this was not well advertised.

Staff received a comprehensive induction and were given protected time for mandatory training each year. Non- clinical staff met regularly with the practice manager to discuss their day to performance and clinical staff received monthly clinical supervision.

Are services caring?
Patients told us they were satisfied with the quality of care and support offered by the practice. They felt they were always treated with dignity by all the staff and doctors. GP's told us they would ensure patients fully understood all their treatment options during consultations.

The practice had an active patient participation group (PPG) that met bi-monthly. We saw the chair of the PPG attended the weekly practice meetings and gave valuable feedback to the practice.

The practice carried out an annual patient's survey to obtain patients views. The results demonstrated that most patients were happy with the service they received. However the key areas that the majority were unhappy with were the appointment system, telephone access and the lack of confidentiality in the waiting room.

Are services responsive to people's needs?
Improvements were required to ensure the practice was more responsive to people's needs.

The practice demonstrated an understanding to the needs of the local population which were, according to Lewisham (CCG), the neediest groups of patients in Lewisham in terms of complex physical, mental and social health care needs. They provided a range of services to meet their needs. However, the A&E attendances by patients from this group remained high.

Services provided at the practice included adult counselling and psychology and children's and young people's therapy, antenatal and post natal maternity care, smoking cessation, holiday vaccination and spirometry.

Summary of findings

Patients told us they found it extremely difficult to get an appointment at the surgery. The GP's who spoke with us said they recognised improvements were needed to enable more patients to see a doctor when they needed to. We noted that 25 per cent of patients did not attend their appointments.

There was a complaints policy and procedure in place. Patients were informed how to make a complaint or comment about the service in the information leaflets given out when people first registered.

Are services well-led?
Staff told us the practice had a supportive open culture. They said they found the leadership team were always accessible.

The practice had a clear vision statement which was 'Maintaining the highest standards of medical care combining evidence based and patient centred approaches'. The vision was discussed with all staff at their annual away days.

The GP partners had monthly meetings and decisions made at this meeting were relayed to staff the following week in the practice meeting. Staff said they felt comfortable about making suggestions or recommendations at the practice meetings or to any of the leadership team. However, there were no formal processes in place to gather feedback from staff.

The practice had a Patient Participation Group (PPG) to seek patient's views. The group met bi-annually. An annual survey of patients was carried out.

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
One GP at the practice was the lead for dementia and end of life pathways. We were told the GP's attended two residential care homes on a weekly basis.

The GPs provided medical care to people living in the care home and also trained the staff in basic nursing care. The GP said they also supported end of life care for patients in these homes.

The practice also offered preventative health measures such as annual check-ups and flu vaccinations for patients in this population group.

People with long-term conditions
The GP's told us they constantly strove to improve the care of patients with chronic diseases. Nurses in the practice had specialisms such as working with patients with chronic obstructive pulmonary disease (COPD), asthma, diabetes and hypertension.

The practice had set themselves targets to improve outcomes for these patients and had set up workgroups that consisted of nurses and GPs who worked towards clear targets. They held information days at weekends to help patients understanding about their own conditions and how best to look after themselves.

They also ran a 'virtual clinic' together with the diabetes community specialist nurse where recommendations were made to assist patients who struggled to control their diabetes

Mothers, babies, children and young people
The practice provided childhood immunisations, antenatal and postnatal services for mothers and babies.

The clinicians told us they were happy to see young people on their own if they presented at reception.

There was a sexual health clinic in the upstairs floor of the building where patients in this group were referred to for preventative health advice such as sexual health and contraception.

The working-age population and those recently retired
The practice opened 8am - 8pm weekdays and 8am – 11am on Saturdays. Patients could book and cancel appointments online.

The practice took part in the adult health screening programme where patients over forty years of age were offered a health check.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

The practice had two GPs who specialised in drug and alcohol misuse. Both had completed parts 1 and 2 of the Royal College for General Practitioners (RCGP) Alcohol Misuse certificate. A community drug dependency worker was also attached to the practice. They attended once a week to provide additional support for patients.

The practice ran a community alcohol detoxification service, particularly for people who did not wish to be affiliated with the drug and alcohol service locally.

Health checks were routinely offered to adults with learning difficulties. The practice would post out an easy to read questionnaire beforehand

People experiencing poor mental health

Four per cent of patients registered at the practice suffer with long term mental illness (LTMI). Nurses at the practice provided injections of anti-psychotic medication to people stabilised on this medication.

The practice had a good working relationship with the community mental health services (CMHT). They carried out joint visits to support patients at home. One GP at the practice held a weekly surgery for local care homes for people with LTMI.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection and received 16 completed Care Quality Commission (CQC) feedback cards.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care.

We looked at the completed CQC comment cards and most were very positive about the practice. However a number of patients had commented that it was difficult to contact the surgery to book appointments and often when they attended the surgery they would have to wait more than 15-20 minutes past their appointment time before they saw they the doctor.

In the most recent patient survey carried out by the practice, access appointments and contacting the surgery had scored very low, whilst patients felt the treatment and care was excellent. The 2013 national GP survey results also indicated patients were happy with the care they received and that they had confidence in the GP's at the practice.

Areas for improvement

Action the service SHOULD take to improve

The practice did not always obtain references before people started work.

Patients told us they found it extremely difficult to get an appointment at the surgery. They said it was difficult to get through on the phone and when they attended the surgery in person they would have to queue for some time.

The practice had a large amount of people (25%) who did not show up for their appointments. The GP's said they had tried to address this in various different ways; however the figure had not reduced.

There were no formal processes in place to gather feedback from staff.

The last infection control audit had been carried out in 2010.

The practice did not have a defibrillator and had not carried out a risk assessment regarding responding to emergencies.

Outstanding practice

The practice had two GPs who specialised in drug and alcohol misuse. Both had completed parts 1 and 2 of the Royal College for General Practitioners (RCGP) Alcohol Misuse certificate. They ran a community alcohol detoxification service, particularly for people who did not wish to be affiliated with the drug and alcohol service locally.

Care Quality Commission

Rushey Green Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspector was accompanied by a GP, a practice nurse, CQC Inspector and an expert by experience. Everyone on the team was granted the same authority to enter Rushey Green Group Practice as the CQC inspectors.

Background to Rushey Green Group Practice

The Rushey Green Group Practice provides GP primary care services to around 12,000 people living in the borough of Lewisham. They do not have an upper limit therefore registration is always open. The practice is staffed by eight GP's, six nurses, a healthcare assistant, practice manager and six reception staff. They have one surgery in Hawstead Road, Lewisham. They have an arrangement with another provider for an out of hours service.

Lewisham is the 16th most deprived out of 326 local authorities and has a higher than average proportion of Black and Minority Ethnic residents. The deprivation levels, child poverty, childhood obesity, drug misuse, new cases of tuberculosis, acute sexually transmitted infections are significantly worse than the England average.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them

How we carried out this inspection

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

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as NHS England, Lewisham Clinical Commissioning Group and Health Watch to share what they knew about

Detailed findings

the service. We carried out an announced visit on 8th July 2014. During our visit we spoke with a range of staff (doctors, care assistant, deputy practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

There were processes in place to report significant events and any incidents that occurred at the practice. These included completing an incident book or a significant events form. All staff we spoke with were aware of the procedures for reporting incidents and gave examples of when they had used them. Thee practice manager reviewed any reported incidents in consultation with the lead GP for this area to determine if any immediate steps needed to be taken. Agreed actions would then be implemented.

The practice manager circulated safety alerts to the nurses and GP's by email, and also ensured staff not present at the practice meetings were made aware of any changes to procedures as a result of incidents that occurred.

There were arrangements in place to communicate with external agencies where there were concerns. For example exchanging safeguarding information with social services.

Learning and improvement from safety incidents

The practice learnt when things went wrong and made the necessary changes to prevent recurrence. The management team reviewed all incidents to determine whether any immediate actions were required, such as changes to policies and procedures. For example following an incident involving unauthorised access to prescription pads, procedures were implemented to ensure the pads were always kept secure by the GP's.

There were monthly significant event meetings attended by all the partners, and any learning or recommendations were shared with staff at weekly practice meetings.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for adults and children were in place. These were in line with local guidance relating to multi-agency safeguarding procedures. The policies included easy to follow flowcharts showing how to report concerns to social services.

One of the GPs was the safeguarding lead for the local Clinical Commissioning Group (CCG) as well as the practice. They provided safeguarding training for staff at this practice and other practices in the area. All staff we spoke with said they had attended safeguarding training for both adults and children within the last year. Non-clinical staff were trained to Level 2 in child protection and clinical staff Level 3. Staff files confirmed training was updated annually.

There was an alert in the computer record and in family notes in cases where social services had been involved as a result of court orders.

Staff were able to demonstrate how they had identified and responded appropriately to safeguarding concerns. For example, the practice nurse gave an example of when they had raised a concern to the GP safeguarding lead about the condition of leg ulcers on a person who lived in a care facility. They raised it with the lead partner and it was escalated to the district nurse and social services.

Monitoring Safety & Responding to Risk

The practice monitored safety through a risk identification and assessment tool which was completed annually and included risks to staff, premises and any clinical risks. Where risks had been identified, a plan had been put in place to address them. There were procedures in place for staff shortages or loss of key workers.

Records showed that the practice's fire alarm system was tested monthly and had a maintenance check annually. Staff received training in fire safety and the practice had a named fire safety lead. Although fire evacuation drills did not occur it had been identified on the risk assessment and all staff were clear about where people should go if they had to evacuate and who would have overall responsibility for ensuring the evacuation happened safely. Annual building health and safety checks were also carried out.

Medicines Management

The nurse partner was responsible for the management of medicines in the practice and there were up to date medicines management policies and staff were familiar with them.

Medicines, including vaccines were kept in a locked fridge. Records showed that fridge temperatures were checked daily to ensure the fridge was always at the correct temperature and there were procedures to follow if it was not. We checked a sample of immunisations and medicines and they were all in date.

Are services safe?

The nurse described the ‘cold chain’ for medicines. ‘Cold chain’ refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines. We found the procedure was satisfactory.

When children were immunised the practice recorded it in the child’s health record and in the computer records. Drug name, batch number, expiry date, site of injection, consent given and relationship of the accompanying adult to the child was all recorded. We were told the practice refused consent from non-first-degree relations of the child.

There were arrangements in place for repeat prescriptions to be made available within 48 hours. Patients had to attend the practice to re-order prescriptions as they did not accept telephone requests. Most repeat prescriptions were for two months and a patient’s medication would be reviewed with a GP annually. GP’s told us they discussed side-effects of medicines when they were initially prescribed and during medication review appointments. Prescription pads were kept in a locked cupboard in reception.

Cleanliness & Infection Control

One GP was the lead for infection prevention and control (IPC) and the practice had an IPC policy and procedure in place. All staff we spoke with were familiar with the policy and had attended infection control training. However the last infection control audit was carried out in 2010, which is not in accordance with the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

We found the practice clean and hygienic. The practice manager told us it was cleaned twice daily by cleaners they employed directly. Cleaning schedules were in place for all areas of the practice and the cleaning arrangements ensured the risk of cross infection was minimised. Waste was separated and clinical waste was collected weekly by a waste management company. There were adequate hand-washing facilities in treatment rooms and hand washing posters were displayed in the toilets.

Staffing & Recruitment

The practice had appropriate recruitment and selection processes in place. We checked staff records and found references were sought prior to employment for most staff. However for one member of staff, only one reference had been obtained and only after the person had commenced work.

Disclosure and Barring Service (DBS) checks were carried out prior to employment for clinical staff. The safeguarding lead told us they would risk assess whether a DBS check was required for non-clinical staff as they were never left alone with patients. The risk assessment process included staff being asked to declare any previous convictions or sign a declaration to confirm they had not committed any offences. However, the practice had not carried out DBS checks for non-clinical staff who were acting as chaperones.

We were told by a GP that staff levels had been reviewed in the previous year which resulted in increased GP sessions, nurse time and reception time. Whilst nurses felt the increase in nursing staff was very helpful, reception staff felt they required more staff as it could be very challenging when someone was absent, especially when people were absent for long periods.

Dealing with Emergencies

The practice had a continuity and recovery plan in place to deal with emergencies. This covered areas such as long or short term loss of access to the building, loss of the computer system, loss

of access to paper medical records, loss of the telephone system, incapacity of GPs and loss of water, gas and electricity supply. The plan was reviewed every year at the practice away days.

The practice had procedures in place to deal with medical emergencies. All staff had received training in basic life support. An emergency drugs box was kept in reception with a full range of emergency drugs. We inspected the box and found all drugs were in date. The resuscitation box we checked contained a bag valve mask resuscitator which would be used to provide assisted ventilation to people who were either not breathing or were having trouble breathing. Two oxygen cylinders were also available. The practice did not have a defibrillator and had not carried out a risk assessment regarding responding to emergencies.

Equipment

The practice had effective systems to ensure that patients who used the service were not harmed as a result of unsafe

Are services safe?

equipment. Annual portable appliance testing had been conducted on all electrical equipment in the practice. We saw maintenance and service logs for medical equipment such as blood pressure monitors.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The GP's told us they used National Institute for Health and Care Excellence (NICE) guidelines to inform the care and treatment they gave their patients. They also used information available online to support their discussions with patients about their diagnosis and treatment options.

The practice had developed their own hypertension protocol based on NICE guidance. This involved creating a database to monitor blood pressure performance. The **protocol** defined what actions should be taken with regards to high blood pressure results. The database would automatically be populated from GP records on the system and was also used by nurses in the practice. The practice was in the process of creating a similar one for diabetes monitoring.

The nurse partner held monthly meetings with the nursing staff to discuss clinical practice updates. Records demonstrated they had discussed the use of the protocols for diabetes and hypertension. Nurses also provided feedback if they had attended study days or training. For example one nurse had attended training arranged by the clinical commissioning group (CCG) for alcohol screening. As a result they had amended their new patient check list to include a template for recording alcohol consumption.

The practice held quarterly 'clinical topic' meetings. These meetings were attended by all clinicians in the practice. We also saw that clinical staff used email communication to seek guidance and advice from colleagues.

There was evidence that the practice understood the importance of mental capacity. GP's told us they were always mindful that it was context sensitive and varied over time. They said it often needed teamwork to achieve the best answer. They gave examples of assessing a patient, in line with the Mental Capacity Act 2005 (MCA 2005), who had a "do not resuscitate" notice. One of the practice nurses raised concerns and the patient's capacity was reviewed again and they were deemed not to have capacity.

Management, monitoring and improving outcomes for people

The practice participated in clinical audits and bench marking against other practices in the borough. It used the Quality and Outcomes Framework (QOF) to inform them of areas where they needed to improve. The QOF is a voluntary incentive scheme for GP practices. There was a GP practice lead for all key areas in the QOF, such as clinical, organisational, patient experience and additional services.

The GP's told us they also carried out their own audits. For example the practice had carried out a clinical audit in September 2013 regarding the take up of immunisation by patients with Hepatitis C status. The audit indicated take up was low. As a result a protocol had been developed for the practice. To complete the audit cycle a re-audit was scheduled to assess the impact of the new protocol in September 2014.

At the time of our inspection the practice was participating in a Lewisham-wide review. They were bench marking their referral rates in the areas of dermatology, gynaecology, ENT and gastroenterology. The purpose of the project was to compare time and appropriateness of referrals to hospital specialist services.

Effective Staffing, equipment and facilities

All new staff received a comprehensive induction which included shadowing another staff member, familiarisation of key policies and procedures, key responsibilities of the job and the computer system.

Non–clinical staff told us they had regular opportunities to hold discussions about their work during the week, as the practice manager operated an 'open door' policy. They said they also had individual meetings every six weeks where they could raise any concerns. Clinical staff received monthly clinical supervision.

All staff received annual appraisals. Non-clinical staff were appraised by the practice manager and the nurses by the nurse practitioner. All GP's had been through the standard appraisal process and revalidation dates had been set. Staff records demonstrated that most appraisals were up to date, however some reception staff had not yet been appraised and had been in post for more than 12 months. We saw performance and personal development were discussed at these meetings. There were arrangements in place to support clinical staff through the revalidation process. Revalidation is the process by which all clinical staff who hold a license to practice have to demonstrate to their professional bodies that they are up to date, fit to

practice and compliant with the relevant professional standards. For example the practice nurses were supported to attend study days in regards to any updates in key aspects of their role.

The practice manager kept a training matrix for all staff employed in the practice to enable them to see at a glance when staff training was due. Training was arranged according to job role and we saw that all training was up to date. All staff were given protected time for mandatory training each year. Each clinician had two weeks study leave and were allowed time to pursue their specialisms.

Working with other services

The practice had close working relationships with other health and social care professionals. For example they met with palliative care nurses monthly. Every patient in this group had a named GP. If the responsible GP was not present at the meeting they were subsequently notified of any actions. The GP who was responsible for this area of work told us they had to ensure that each patient had a care plan which included an agreed resuscitation plan.

The GP lead for mental health said they have a very good working relationship with the community mental health services. However, the Community Mental Health team (CMHT) were in the process of reorganisation and were therefore unable to hold regular meetings at present.

The practice worked closely with the health visiting team as Lewisham had a high proportion of families that had complex needs. Vulnerable family meetings were held monthly and were attended by nurses, GP’s and health visitors.

Health Promotion & Prevention

The practice provided additional services such as an asthma clinic, child health and development clinics, drug and alcohol services, counselling (adults children and young people), minor surgery, obesity management clinic and travel health. These clinics were advertised in the waiting room and in the practice information leaflet.

All nurses and GPs were trained to Level 1 smoking cessation. One nurse was trained to Level 3 and prescribed nicotine patches. However we found that although the practice ran a smoking cessation clinic there was no information displayed about it.

The practice supported a ‘Time Bank’ charity by providing office space in their building. The community time exchange helped patients with small jobs, such as gardening. Patients could gain time credits and spend them doing jobs for other people. Staff said it had proved useful for elderly and mental health patients in relation to preventing social isolation.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with eight patients during the inspection, including a member of the practice's Patient Participation Group, who told us they were satisfied with the quality of care and support offered by the practice. They felt they were always treated with dignity by all the staff and doctors.

Consultations took place in private. The practice had a chaperone policy and procedure. Signs were displayed in the waiting rooms encouraging people to speak with the doctor if they wanted someone to be with them during examinations.

The reception area was in a large open waiting room and on the day of our inspection it was very busy. We observed staff speaking with patients with compassion and empathy despite the fact that some patients displayed challenging behaviour.

We asked reception staff if there was a place in the practice where patients could speak with them in private and were told they would take them to the practice manager's office if this was empty or talk with them in an alternative room. We noted there were no signs advising people that they could ask to speak with staff in private and were told patients already knew this. However the practice said they would ensure information was displayed in future.

We were told that the majority of patients were Afro-Caribbean, Black African and Polish. Reception staff told us they had access to language line, a telephone interpretation service for the small proportion of patients who did not speak fluent English. There was a range of information displayed in the waiting room which was all in English. The practice manager told us this was because they would have to produce the information in too many different languages and information was constantly being updated.

We asked what support was provided for bereaved families and was told the practice gathered notifications of death from multiple sources, including notes on the patient record, hospital letters or family members. Condolence cards were sent to bereaved families and some GP's said they often followed this up with a personal phone call to offer support a few weeks later.

Involvement in decisions and consent

Patients we spoke with told us they felt involved in all decisions about their care and treatment. They said the GP's would ask for their consent before any care or treatment was given. All felt the GP's acted in accordance with their wishes. The GP's told us they ensured patients understood what was being discussed, responded to any concerns and would ask for verbal consent before proceeding with examinations and other medical procedures. Patients were encouraged to make appointments to see the same doctor except where they needed to see someone in an emergency. The GP patient survey indicated that 78% of patients felt that GP's were good at involving them in decisions about their care

The practice had an active patient participation group (PPG) that met bi-monthly andthe chair of the PPG attended the weekly practice meetings. The group were regularly consulted and gave valuable feedback to the practice. The results of the most recent national GP patient survey carried out by the clinical commissioning group (CCG) in 2013 indicated patients were mainly satisfied with the service they received from the practice. Patients however expressed concern about making an appointment, stating that it was very difficult to contact the surgery by phone. As a result, the PPG were involved in discussions about how to improve telephone access.

The practice also carried out their own annual patient survey. The last survey ran from November 2013 to March 2014 and over 205 questionnaires were completed. The survey was advertised in the practice newsletter, posters in the waiting room, the practice website and social media. The results were similar to the national GP patient survey, highlighting issues about access.

The practice had created an action plan to address the areas of concerns identified by the survey. Staff had clear lead areas of responsibility and there were clear timescales for implementation. For example one GP was leading a work group addressing access to the practice, another was the lead for public interface to be responsive to information in timely and transparent ways and provide up to date information on all media forms.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice demonstrated an understanding of the needs of the local population. The practice catered for some of the most vulnerable groups of patients in Lewisham such as the homeless, patients with drug and alcohol addiction and mental health problems. These patients had complex physical, mental and social health care needs. As such the practice provided a range of specialist services for these groups, such as a community alcohol detoxification service, practice nurses carried out home visits to all housebound patients once a year and nurses at the practice provided injections of anti-psychotic medication to patients.

Other services provided at the practice included adult counselling and psychology and children's and young people's therapy, antenatal and post natal maternity care, smoking cessation, holiday vaccination and spirometry.

We were told the CCG had expressed concern about the low levels of take up for child immunisation and had informed the practice they needed to improve. The practice only had a 25 per cent take up rate. The GP told us they reviewed their systems to improve the process for contacting and referring patients to other services. The practice had begun writing, phoning and texting new mothers. If there was no response, the child was referred to a health visitor. As a result the take up had only slightly improved.

Information we received before the inspection indicated that A&E attendances by patients from this practice was very high. The GPs told us there were two key reasons for this; the local A&E was located near the practice and the practice had a high proportion of high-risk patients (drug users, alcoholics and patients with mental health conditions) who attended A&E frequently. The CCG had recently funded a pilot to work with this group of patients. This involved working with social workers and mental health support staff to inform people about the consequences of their choices. We asked if the fact that it was difficult to get an appointment generally contributed to this. The GP's felt that was a possibility.

Patients were referred to a number of different hospitals including Lewisham, Kings College Hospital, Guys and St Thomas's. The IT system allowed for direct sharing of information about patients with these hospitals, but where necessary additional information was faxed. Reception staff told us they chased test results on a weekly basis as they often did not receive them back from the hospitals in a timely way.

The practice was accessible to patients with mobility difficulties as the reception and treatment rooms were based on the ground floor and had step free access. Toilets were available for the patients and were accessible to wheelchair users.

Access to the service

Patients told us they found it extremely difficult to get an appointment at the surgery. They said it was difficult to get through on the phone and when they attended the surgery in person they had to queue for some time, and often when they got to reception all the appointments for the day had gone. Some said on occasions it could take weeks to see a doctor, even when it was an emergency. According to the 2014 national GP patient survey, the practice was amongst the worst for the proportion of patients who found it easy to access the practice via telephone. The practice performed significantly worse than other practices in the CCG area in relation to this indicator.

We discussed the appointments system with the GP's who said they recognised improvements were needed to enable more patients to see a doctor when they needed to. The lead GP said patients could call at 8.00am to make emergency appointments and there were plans to increase the amount of telephone lines. They said they had introduced on-line booking and the ability to book by text messaging, however the take up for these had been very slow. They were planning various information sessions to promote these services.

Half of each GP's appointments were could be booked four weeks in advance and half on the same day. There was a daily duty GP to see urgent cases and each GP had two appointments at the end of each surgery for telephone consultations. They also offered extended hours from 8 to 8 Monday to Friday and 9 to 11 Saturday. We were told this was in excess of contracted hours. The partners said they routinely analysed their appointments to improve efficiency. However they had a 20-25 per cent 'do not attend' (DNA) rate which was very high. The GP's said they had tried to address this in various ways, such as advising patients they could request advice by e-mail and texting patients to remind them of their appointments. They

Are services responsive to people's needs?

(for example, to feedback?)

continued to treat this as a priority and it was included in their annual work plan and the action plan developed for responding to the Patient Participation Group (PPG) concerns.

The practice participated in a minor ailments advice requests (MARS) process, which was a borough-wide initiative. When patients presented at reception with minor ailments the receptionist offered patients a 'MARS' form, which entitled them to free prescription e.g. Paracetamol for minor ailments such as head colds or cream for extremely dry skin. Reception staff had a list of ailments they could use the form for. This was limited to three prescriptions for the same ailments, and then patients would have to make an appointment to see a GP. Patients we spoke with told us this was helpful on occasions.

Concerns & Complaints

There was a complaints policy and procedure in place. Patients were informed how to make a complaint or comment about the service in the information leaflets given out when people first registered with the practice. Leaflets were available in the waiting room and signs about how to complain were displayed in the practice.

We looked at a sample of complaints they had received and noted they had been responded to in line with their complaints procedure. Most complaints were about not being able to book an appointment and the length of time patients had been placed on hold by reception. The practice manager said they had changed the on hold process, so the patients were not placed on hold for more than two minutes if at all. Staff told us that complaints were discussed regularly in the practice meeting. We saw evidence to confirm this.

Are services well-led?

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

Our findings

Leadership & Culture

A partner at the practice was the CCG's clinical director therefore had a population overview for the area and told us the practice strived to align its strategies with the needs of the local area.

The practice had a clear vision statement which was ''Maintaining the highest standards of medical care combining evidence based and patient centred approaches'.

Staff told us the practice had a supportive open culture. They said they found the leadership team were always accessible.

Governance Arrangements

All doctors had 'lead' areas such as safeguarding, infection control and significant events. Staff would go to the relevant leads for information or if they had any concerns in these areas.

The governance meeting schedule included monthly partners meetings. Management team decisions were relayed the following week to the practice meeting. Six weekly practice meetings were held for all staff at the practice and six weekly vulnerable families meetings were attended by partners and other relevant external agencies. Significant events meetings and palliative care meetings were held every eight weeks.

Five work streams had been identified at the practice's annual away day, which were diabetes, hypertension, access, practice environment and practice interface (to external parties). Each had a nominated lead, not always a partner, a work group and work plan. Some groups had Patient Participation Group (PPG) representation. Each group fed back in turn at monthly practice meeting attended by all GPs and staff.

Systems to monitor and improve quality & improvement (leadership)

The practice had a programme of audits to monitor the quality of the services provided. The practice also used the Quality and Outcomes Framework to inform them of areas where they needed to improve.

Access had been identified as a key area for improvement and the lead for this area had set targets for reducing missed appointments and was in the process of reviewing GP duty and appointments types when we inspected.

The practice participated in a Lewisham-wide referrals to hospital comparison peer review with four other local GP practices.

Patient Experience & Involvement

The practice had a Patient Participation Group (PPG), to seek patient's views, which met bi-annually. Minutes of PPG meetings were sent to all staff and presented on the practice website. The chair of the PPG attended the six weekly practice meeting.

An annual survey of patients was carried out. The issue of access dominated the responses to the most recent survey conducted. The annual work plan was shared with patients via the PPG, on the website and was available at reception.

The practice held regular weekend open days. Topics covered so far were diabetes and hypertension. We saw plans were in place to hold one this month to address access.

Practice seeks and acts on feedback from users, public and staff

The lead GP said a key outcome of the away day was to involve the staff in the vision and strategy. However we found that some staff we spoke with did not know the vision for the practice.

Staff said they felt comfortable about making suggestions or recommendations at the practice meetings or to any of the leadership team. However, there were no formal processes in place to gather feedback from staff. The practice held an annual away day with staff and the lead GP told us staff feedback formed part of this. However, they agreed that staff may want processes to feedback individually or anonymously.

Management lead through learning & improvement

Clinical staff were supported to complete the continual professional development required to maintain their professional registration. Non-clinical staff agreed development targets for the coming year and we saw there were opportunities for them to attend training both related

Are services well-led?

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

to their job and for personal development. For example reception staff had attended smoking cessation training even though it was not relevant to the job they were currently doing.

The lead GP told us they had commissioned an external review of the administrative structure. They said they accepted the recommendations and added the assistant practice manager post to the structure as a result.

Identification & Management of Risk

One of the partners was the lead on 'risk'. We saw that where potential risks were identified risk management plans were drafted with clear actions to be taken to minimise or alleviate the risk.

The practice had systems and audits in place to ensure that all equipment used was regularly serviced and maintained in accordance with the manufacturer's instructions. We saw service contracts, weekly and daily checks and records which showed that all had been completed.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

One GP at the practice was the lead for dementia and end of life pathways. We were told they attend two residential care homes on a weekly basis. The GP provided medical care to people living in the home and also trained the staff in basic nursing care, such as blood pressure monitoring and urinalysis.

The GP said they also supported end of life care in these homes if the patient wanted to die at home. They meet with McMillan nurses every six weeks to discuss patients receiving palliative care.

The practice also offered preventative health measures such as annual check-ups and flu and shingles vaccinations for patients in this population group. They had a named GP for all their patients over 75.

The practice supported a 'Time Bank' charity which helps patients with small jobs such as gardening. Patients could gain time credits and spend them doing jobs for other people. They said it has proved useful for their elderly patients particularly in relation to preventing social isolation

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The GP's told us they constantly strove to improve the care of patients with chronic diseases. Nurses in the practice had specialisms such as working with patients with chronic obstructive pulmonary disease, asthma, diabetes and hypertension.

The practice nurses carried out home visits to all housebound patients once a year. This was to ensure their chronic disease was monitored and to perform annual medication reviews. We were told they worked closely with the community matron.

We saw the 2014-15 work plan included hypertension and diabetes. The practice had set themselves targets to improve outcomes for these patients, for example to reduce the number of patients in this group by at least 15 per cent. The aim was to the lower blood pressure (BP) of people whose BP was excessively high. They had workgroups that consists of nurses and GPs. The workgroup feedback on progress each quarter at the practice meeting.

The GP said they worked with quite a challenging mobile population and felt it was important to empower patients to self-care as much as possible. They tried to ensure these patients had as much understanding about their own conditions and how best to look after themselves. They held information days at weekends and we saw plans were in place for future open days.

The diabetes nurses ran a weekly clinic to look after the most poorly controlled diabetics. We saw they also ran a 'virtual clinic' together with the diabetes community specialist nurse where recommendations were made to assist patients who struggled to control their diabetes. The diabetic practice nurses were trained to initiate insulin commencement in the community.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice provided childhood immunisations, antenatal and postnatal services for mothers and babies. We saw that these clinics were promoted in the practice information leaflet. The practice had begun writing, phoning and texting new mothers. If there was no response, the child was referred to a health visitor. As a result the take up had only slightly improved.

Staff told us that they endeavour to see under-fives on the same day of appointment request, if not the same day then they were always seen the following day.

Clinicians told us they are happy to see young people on their own if they presented at reception. They said they have discussed the use of a credit card size access card for young people which they could present at reception to help them make appointments on their own. We saw a workgroup was currently reviewing this.

There was a sexual health clinic on the upstairs floor of the building where patients in this group were referred to for preventative health advice such as sexual health and contraception.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice opened 8am - 8pm weekdays and 8am – 11am on Saturdays for patients who were unable to get to the surgery during the week due to work commitments. Patients could book and cancel appointments, order repeat prescriptions and update personal details online.

The GPs provided phone consultation for patients who could not come to the surgery during working hours.

All patients over forty years of age, who did not have any on-going health concerns, were routinely offered a health check in line with the adult health screening programme.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had two GPs who specialised in drug and alcohol misuse. Both had completed parts 1 and 2 of the Royal College for General Practitioners (RCGP) Alcohol Misuse certificate. One GP was also the Lewisham substance misuse lead. The GP partners told us (?) they appointed the substance misuse lead GP's as they were mindful of the local population needs. A community drug dependency worker was also attached to the practice. They attend once a week to provide additional support for patients.

The practice ran a community alcohol detoxification service, particularly for people who did not wish to be affiliated with the drug and alcohol service locally.. This service was commissioned by the local authority and was being reviewed and expanded at the time of our visit.

We were told this group of patients also had a number of physical, mental and social health needs and as such were allocated more appointments generally or spent longer time with the GP's when they visited the practice.

The practice had reviewed work practices as patients from this group had presented some challenges and risks either to themselves or to other patients whilst at the practice. We saw that rather than removing them from their list, risk assessments had been carried out and safeguards were implemented to minimise or alleviate the risks presented.

Health checks were routinely offered to adults with learning difficulties (LD). The practice would post out an easy to read questionnaire beforehand. We saw the practice had supported a family with a young person with LD. The family had complex needs, therefore the practice had acted as the lead to ensure the young person received the appropriate support in the community. Meetings had been arranged outside of the normal surgery times to facilitate this.

Records were coded where a patient had a particular need, for example if they were deaf or visually impaired. This was so clinicians would come out to the waiting area instead of calling them on the electronic board.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

Four per cent of patients registered at the practice suffer with long term mental illness (LTMI). There were also a number of patients registered who had less severe mental illness and depression.

Nurses at the practice provided injections of anti-psychotic medication to people stabilised on this medication.

The practice has a good working relationship with the community mental health services (CMHT). They carried out joint visits to support patients at home. They also provided outreach services to patients with LTMI to ensure they received physical health checks when patients did not attend for review. They liaised with pharmacists who provided their medication and contact the keyworkers from the CMHT when they were unable to contact patients.

One GP at the practice held a weekly surgery for local care homes for people with LTMI; one for neurological disabilities, another for brain injuries and one for a probation hostel for ex-offenders

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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