Honor Oak 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.

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Overall summary

Honor Oak Group Practice is a general practice (GP) surgery that operates from a single premises located in Brockley, within the Lewisham Clinical Commissioning Group (CCG) area. Lewisham CCG is a membership organisation of 44 local GP practices and is responsible for commissioning health services for the local population. Census data shows an increasing population and a higher than average proportion of Black and Minority Ethnic residents in Lewisham. Life expectancy is 6.8 years lower for men and 4.6 years lower for women in the most deprived areas of Lewisham than in the least deprived areas. The number of people between 20 and 39 and children under ten is significantly higher than the England average.

The service is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder and or injury. The practice currently has 9246 patients on its list.

We carried out an announced inspection on 09 July 2014. The inspection took place over one day and was led by a lead inspector, a GP advisor, a practice manager and an expert by experience.

All the patients we talked with were happy with the care they received. We received 40 comment cards and spoke with 16 patients. Almost all had very positive comments about the care and service provided by the surgery. The majority of the participants of the 2013/2014 patient survey undertaken by the practice were satisfied with their last consultation, had felt involved in the decision involving their care and had rated their experience of making an appointment as 'very good' or 'fairly good'.

We spoke with all the staff members available on the day of our visit. These included three GPs, the practice manager, counsellor, a clinical nurse and five members of the reception and administration team.

The GP partners provided a visible leadership, there were appropriate governance arrangements and staff we spoke with told us the GP partners and practice manager were very supportive of them. The practice was responsive to the needs of the vulnerable patients and homeless people, and there was a strong focus on caring for patients and on the provision of a patient-centred care, especially for those with disabilities. Staff were very clear of their roles in regards to monitoring and reporting of incidents, safeguarding vulnerable people and children, and infection prevention and control.

The practice worked with the community teams and charities to provide effective care for people with mental health issues and the homeless and vulnerable people, and had the highest percentage in the Lewisham CCG area for people receiving NHS health checks.

Overall we found that the practice provided an effective and caring service which was safe, well-led and responsive to people's needs. There were systems in place to monitor and manage outcomes to help provide improved care, and staff shared best practice via internal arrangements and meetings. The practice was well-led, staff were supported appropriately and patients' safety was maintained as systems were in place for reporting, recording and monitoring significant events.

We noted areas of good practice including in management of patients with complex conditions, safeguarding of children, and management of obesity. The various population groups including older people, people with long term conditions, mothers, babies, children and young people, the working age populations and those recently retired, people in vulnerable circumstances and people experiencing poor mental health received a care that was effective, caring, safe, responsive and well-led.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the organisation. Staff we spoke with were trained in and aware of their responsibilities for safeguarding vulnerable adults and children. The equipment and the environment were maintained appropriately, and staff followed suitable infection control practices. Vaccines and medicines were stored suitably and securely and checked regularly to ensure they were within their expiry dates.

Are services effective?

Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. Audits of various aspects of the service including prescribing were undertaken at regular intervals and changes were implemented to help improve the service. The provider worked with other health and social care services, and information was shared with relevant stakeholders such as the Clinical Commissioning Group (CCG) and NHS England. Staff were supported in their work and professional development.

Are services caring?

The people we spoke with told us they were treated with dignity and respect. Patients and carers felt well informed and involved in decisions about their care. All the patients we spoke with and almost all the comments we received were complimentary of the care and service that staff provided.

Are services responsive to people's needs?

Patients' needs were suitably assessed and met. Feedback from patients was obtained proactively and the service acted accordingly. The practice learnt from people's experiences, concerns and complaints to improve the quality of care. Arrangements had been made to help vulnerable people access care.

Are services well-led?

The practice was well-led and the culture within the practice was open and transparent. Risks to the effective delivery of service were assessed and there were suitable business continuity plans in place. Patients and PPG members told us that they felt listened to and involved in the decisions about the care. The staff were well supported and the receptionist team were a well-established team with long serving members. They worked closely together and felt able to raise concerns. Completed clinical audits had been undertaken.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice was responsive to the needs of people aged 75 and over.

Older people were cared for with dignity and respect. The practice was responsive to their needs, and worked with other health and social care providers to provide safe care. Support was available for terminally ill and housebound patients.

People with long-term conditions
The practice was responsive to the need of people with long-term conditions.

People in this population group received safe and effective care which was based on national guidance. Care was tailored to people's needs, had a multi-disciplinary input and was reviewed regularly.

Mothers, babies, children and young people
The practice was responsive to the needs of mothers, babies, children and young people.

There was evidence of good multidisciplinary working with involvement of other health and social care professionals. Staff we spoke with were aware of and had received training on safeguarding vulnerable adults and child protection. Staff understood the policies and processes and knew what action to take if they needed to raise an alert. Childhood immunisations were administered by the practice nurse in line with national guidelines.

The working-age population and those recently retired
The practice was responsive to the needs of working people and those recently retired.

The practice responded to concerns and feedback from patients in this group to ensure people received care based on their needs. The practice offered health checks, vaccinations and health promotion advice including on smoking cessation.

People in vulnerable circumstances who may have poor access to primary care
The practice was responsive to the needs of people in vulnerable circumstances.

Summary of findings

There was evidence of multidisciplinary working with involvement of other health and social care professionals. The practice worked in partnership with a local charity to provide support to homeless people. Staff had been provided training on safeguarding vulnerable adults and child protection.

People experiencing poor mental health

The practice was responsive to the needs of people with poor mental health.

The practice ensured that good quality care was provided for patients with mental health illnesses. The practice was well-led, responsive to patients' needs and staff told us that they worked with the community teams to ensure a safe, effective and co-ordinated care.

Summary of findings

What people who use the service say

All the people we spoke with during the inspection, including members of the Patient Participation Group (PPG) stated that they were treated with kindness and respect both by doctors and nurses and by the practice reception staff. The majority of the participants of the 2013/2014 patient survey undertaken by the practice were satisfied with their last consultation, had felt involved in the decision involving their care and had rated their experience of making an appointment as 'very good' or 'fairly good'. Almost all the comment cards we received had very positive comments about the staff and the care people had received. People told us they were very happy with the medical care and treatment at the practice.

There were varied opinions regarding the availability of appointments. Some people told us they were very happy with the appointment system though others stated they had a lot of trouble in booking their appointments and getting through on the phone.

The last GP patient survey (latest results published in July 2014) found that more than 80 per cent of respondents felt that the last GP they saw or spoke to was good at listening to them, involving them in decisions about their care and was good at explaining tests and treatments. For these three areas the practice results were higher than the CCG average. The survey also found that 55 per cent of respondents said the last nurse they saw or spoke to was good at treating them with care and concern . This was however, lower than the CCG (regional) average of 72 per cent. Similarly, though 64 per cent of respondents had confidence and trust in the last nurse they saw or spoke to, it was lower than the CCG (regional) average of 80 per cent . Also 49 per cent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care, which was lower than the CCG (regional) average of 63 per cent.

Areas for improvement

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- Following a safeguarding course the practice created an alert on their computer systems to audit "Accompanying adult" for children. It was now mandatory for staff to record details of the adult who accompanied the child on their visit with the purpose to increase the recording of the accompanying adult.
- The practice had developed an obesity resource pack which provided information on local services, including community dieticians, and also referred patients to weight management programmes.
- The practice undertook a risk profiling audit which helped in identifying relevant patients, especially those with complex conditions, who would otherwise not be identified and could potentially miss out on health and social care support.
- Introduction of an internal alert on the computer system for all patients who had attended A&E in the previous three months enabling GPs to discuss with patients, where relevant, the other available options.
- The practice worked in partnership with a local charity to meet the needs of the homeless people and to provide food vouchers for people in need of emergency food help.

Honor Oak Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP advisor. The team included other specialists including a practice manager and an Expert by experience. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Honor Oak Group Practice

Honor Oak Group Practice provides primary care service medical services to 9246 patients who live in and around the Brockley district in Lewisham local authority area. The practice population has twice the national average of under 5s and half the national average of over 75s and about 40 per cent of the patients belong to black and minority ethnic background. About 2000 patients on the list live in deprived areas including compact, isolated council estates. The practice staff include a practice manager, five partners, one salaried part time GP, one GP registrar, two part time practice nurses, two healthcare assistants (HCA), five reception and three administration staff.

The Medical Centre is open from 7.00am to 6.30pm Monday to Friday. Patients can book appointments in person, over the phone and online.

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. As part of the inspection process we asked other organisations including the CCG, NHS England (NHSE)and Health Watch to share what they knew about the service.

Detailed findings

We reviewed 40 comment cards completed by patients who visited the surgery in the two weeks before our inspection.

We carried out an announced visit on 9th July 2014 between 8:00 a.m. and 5:00 p.m.

During our visit we spoke with a range of staff, including the GP partners, practice manager, counsellor, clinical nurses, receptionists, and administrative staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the practice. Staff we spoke with were trained in and aware of their responsibilities for safeguarding vulnerable adults and children.

The equipment and the environment were maintained appropriately, and staff followed suitable infection control practices. Vaccines and medicines were stored suitably and securely and checked regularly to ensure they were within their expiry dates.

Safe patient care

People's safety was maintained as the practice reported and appropriately recorded safety incidents, complaints and safeguarding concerns. Lessons were learnt and the learning shared when things went wrong. The practice manager told us of the arrangements they had for receiving safety alerts from other organisations. All the staff we spoke with were aware of identifying concerns and issues and reporting them appropriately.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice had a policy document, 'Significant/Critical event toolkit', which was available for staff to refer to if they needed any clarification about reporting incidents. We saw examples of incidents, and meeting minutes that showed incidents were identified, suitably recorded and discussed with practice and community staff to ensure there was learning from them. We were shown examples where lessons had been learnt and protocols amended from reporting of incidents such as when a patient who was on blood thinner medicines had missed their regular blood tests. The incident and learning was shared with community teams so that the patient and other patients on similar medicines could be better monitored.

Reliable safety systems and processes including safeguarding

The practice had policies in place relating to the safeguarding of vulnerable adults, child protection and whistleblowing. One of the partners and the practice manager were the designated leads for child protection and safeguarding adults. Staff we spoke with were aware of their duty to report any potential abuse or neglect issues. Clinical staff including the GPs and both the nurses, and the healthcare assistants (HCAs) had completed Level 3 child protection training and the reception staff had received Level 1 training. Staff had also received training in safeguarding of vulnerable adults. 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.

Monitoring safety and responding to risk

The GPs and the practice manager we spoke with explained the systems that were in place to ensure the safety and welfare of staff and the people using the service. The practice manager and GPs told us about the steps that had been taken to ensure security and safety of people and staff. These included recording details of the people accompanying child patients, reviewing alerts about missing persons, displaying the emergency equipment list to ensure staff could locate it in an emergency, undertaking risk assessments and an annual review of all inventory and equipment in the practice and control of substances hazardous to health (COSHH) and fire safety risk assessments.

Medicines management

The provider had policies and procedures in place to support the safe management of medicines. Medicines and vaccines were safely stored, appropriate recorded and disposed of in accordance with recommended guidelines. We checked the emergency drug kit and found that all drugs were in date. Staff were aware of drugs that were nearing their expiry date at the end of the month and told us that replacements had been ordered. 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. The medicines cupboard and the vaccines refrigerator in the nurse's treatment room were securely locked.

Cleanliness and infection control

Effective systems were in place to reduce the risk and spread of infection. There was a designated infection prevention and control lead. Staff had received training in infection prevention and control and were aware of infection control guidelines. Cleaning schedules for

Are services safe?

different areas were displayed. Staff told us they had access to appropriate personal protective equipment (PPE), such as gloves and aprons. Suitable hand washing sinks, hand cleaning gel and paper towels were available. The practice had undertaken an infection prevention control audit earlier in the year and the identified actions such as improved cleaning in certain areas were being implemented. The waiting area and the consultation and treatment rooms were clean and well-maintained. Equipment such as blood pressure monitors, examination couches and weighing scales were clean. Waste was segregated stored and disposed off appropriately by an external company.

Staffing & recruitment

An up-to-date staff recruitment policy was available and the practice was aware of the various requirements including obtaining appropriate references and undertaking criminal record checks before employing staff. The staff records we looked at showed pre-employment checks such as proof of identity, proof of address, criminal record checks, two references, past employment history, record of qualifications, interview process and occupational health checks had been undertaken in line with the provider's recruitment policy.

Dealing with Emergencies

There were arrangements in place to deal with on-site medical emergencies. All staff received training in basic life support. The practice had an availability of emergency drugs and equipment such as oxygen, masks and defibrillator and these were checked regularly by one of the practice nurses.

A daily fire attendance register was completed by all staff working at the practice. Regular fire drills were undertaken to ensure staff were aware of the evacuation procedures.

Equipment

There were appropriate arrangements in place to ensure equipment was properly maintained. These included regular checks of equipment such as portable appliance testing (PAT) and calibrations, where applicable. The equipment we checked, including blood pressure monitors and vaccine fridges, were clean and well maintained.

Are services effective?

(for example, treatment is effective)

Our findings

Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. Audits of various aspects of the service including prescribing were undertaken at regular intervals and changes were implemented to help improve the service. The provider worked with other health and social care services, and information was shared with relevant stakeholders such as the Clinical Commissioning Group (CCG) and NHS England. Staff were supported in their work and professional development.

Effective needs assessment, care & treatment in line with standards

One of the GPs was the designated lead for National Institute for Health and Care Excellence (NICE) guidelines and reviewed incoming guidelines for changes. If considered relevant they were discussed in practice clinical meetings and by e-mails. Professionals attending external courses fed back to practice meetings to ensure information was cascaded suitably and adapted accordingly.

There was evidence that staff shared best practice via internal arrangements and meetings. The practice had internal referral management system whereby all referrals were first sent internally by e-mail to other GPs. The GPs found it a good learning exercise and support mechanism as the peers were sometimes able to provide a suggestion to try out alternative options.

GPs and clinical staff we spoke with were aware of the requirements of the Mental Capacity Act (2005) and their responsibilities as regards obtaining and recording consent. The practice undertook a risk profiling audit which helped in identifying relevant patients, especially those with complex conditions, who would otherwise not be identified and miss out on support.

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and manage outcomes to help provide improved care. For example, patients who were prescribed certain medications, such as methotrexate, were reviewed by a GP each time a repeat prescription was required.

The practice monitored the A&E attendances of its patients. As data was not available from external providers, it introduced an internal alert for all patients who had attended A&E in the previous three months. When the patients came in for a consultation the GP used the information to discuss with patient, where relevant, what other options there might have been.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF is a national group of indicators, against which practices scored points according to their level of achievement in the four domains of clinical, organisation, patient experience and additional services. One of the GPs told us that they used benchmarking to enable them to compare their QOF scores with other local practices. The GPs told us that their current GP appraisal cycle required audits on early diagnosis of cancer which were being undertaken as needed. Audits had also been undertaken on urinary tract infection, cervical smear recall, 'Did not attends' (DNAs), risk profiling of patients, and on needs of patients for using interpreting services. The results of various audits were analysed to assess the efficacy of the interventions. For example the practice's DNAs which were at 10 per cent were noted to drop by one per cent point following an intervention of increased mobile text reminders. Similarly, the risk profiling audit had for example helped the practice identify a patient with multiple chronic diseases, who was not taking medication. Subsequently the patient was assessed in the practice and better supported to help them with their medication compliance.

Effective Staffing, equipment and facilities

All new staff were provided with an induction and we saw a comprehensive induction manual and checklist that ensured new staff were introduced to relevant procedures and policies.

The provider had identified mandatory training modules to be completed by staff and specific training relevant to clinical staff. This included infection control, safeguarding of vulnerable adults and young people and basic life support training.

Staff received protected learning days along with time for self-learning and support to attend update courses at least annually. Staff we spoke with told us they were clear about their roles and responsibilities, had access to the practice policies and procedures, and were supported to attend training courses appropriate to the work they performed.

Are services effective?

(for example, treatment is effective)

The practice undertook annual internal 360 degree appraisals for all staff where other staff members contributed to each other's appraisal. The practice manager had collated the results, with scores and comments for each GP and nurse, and presented them to a practice meeting.

The GPs were in their revalidation cycle with two GPs having been revalidated in 2013, two due in 2014 and two in 2015. Revalidation is the process by which doctors demonstrate they are up to date and fit to practise. All staff participated in regular supervision meetings and received annual appraisals. Nurse appraisals were done by relevant GP lead and the practice manager.

Equipment and facilities were well maintained and there were regular checks of equipment to ensure it was functioning appropriately. We noted staff coming on the shift signing the daily fire attendance register to help maintain a log of staff that were in the premises. The premises was wheel-chair accessible throughout.

Working with other services

The practice worked with other providers and health and social care professionals to provide effective care for people. The practice had regular multi-disciplinary team meetings which included health visitors, the community matron, social services and district nurses. There were also quarterly meetings with the community mental health and palliative care teams to discuss case reviews of house-bound patients, palliative care patients and those with complex health and social care needs. Monthly clinical meetings were attended by all GPs, nurses and health care assistants.

The practice worked in close co-operation with the local CCG. The practice was involved in local projects for managing substance abuse and was a satellite unit for substance abuse service for the local CCG area. This involves key workers coming to the practice to counsel and see patients. These services are also available to any local CCG patient whose own GP did not provide the services. As part of the project two GPs have also undergone substance abuse training.

Health, promotion and prevention

There were health promotion notices displayed in the reception area of the surgery. This included information on weight management, chlamydia screening and smoking cessation. Along with information available in the practice premises there was health promotion advice available on the practice website. Immunisations were reviewed monthly and the practice figures showed a 90 per cent uptake and for cervical smears it was 80 per cent. The practice had the highest percentage in Lewisham currently for people receiving NHS health checks.

The practice nurses provided health promotion and prevention services such as cervical cytology, and childhood and travel immunisations, including for yellow fever.

As part of its drive to tackle obesity, the practice had developed an obesity resource pack which provided information on local services, including community dieticians, and also referred patients to weight management programmes for adults and children as well as to local gyms. The practice maintained an obesity register and planned to audit their obesity interventions.

Are services caring?

Our findings

The people we spoke with told us they were treated with dignity and respect. Patients and carers felt well informed and involved in decisions about their care. All the patients we spoke with and almost all the comments we received were complimentary of the care and service that staff provided.

Respect, dignity, compassion and empathy

Of the 40 patient feedback cards we received, 28 showed very positive results from patients in terms of the quality of the service, such as the attitude of staff and meeting their needs. Patients we spoke with were very happy with the service and had found the staff efficient and willing to listen to their concerns. The majority of the participants of the 2013/2014 patient survey undertaken by the practice were satisfied with their last consultation, had felt involved in the decision involving their care and had rated their experience of making an appointment as 'very good' or 'fairly good'.

The last GP patient survey (latest results published in July 2014) found that more than 80 per cent of respondents felt that the last GP they saw or spoke to was good at listening to them, involving them in decisions about their care and was good at explaining tests and treatments. For these three areas the practice results were higher than the CCG average. The survey also found that 55 per cent of respondents said the last nurse they saw or spoke to was good at treating them with care and concern . This was however, lower than the CCG (regional) average of 72 per cent. Similarly, though 64 per cent of respondents had confidence and trust in the last nurse they saw or spoke to, it was lower than the CCG (regional) average of 80 per cent . Also 49 per cent of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care, which was lower than the CCG (regional) average of 63 per cent.

A notice setting out chaperoning arrangements was displayed on the front reception area. Most patients we spoke with were aware that they could have a chaperone for examinations. Staff told us patients made little use of this facility and would typically bring relatives if they needed to be accompanied. GP and nurse consultations were undertaken in consulting rooms, which ensured privacy for patients. Staff we spoke with were aware of the need to be respectful of patients' right to privacy and dignity. They told us that they could take confidential calls at the rear of the office. The practice also had access to a counsellor who provided support for a range of mental health issues and also a bereavement service.

The practice had a confidentiality policy and agreement which all staff were required to sign. Staff showed a good awareness of maintaining patient confidentiality.

Involvement in decisions and consent

Patients who attended the practice were provided with appropriate information and support regarding their care and treatment. Most patients we spoke with told us they were involved in decisions about their treatment and confirmed that consent had been obtained before the delivery of their care.

Clinical staff were aware of the need to document consent issues and also the requirements under the Mental Capacity Act 2005 and the need for ensuring that decisions were always taken in the best interests of patient.

We spoke with two members of the Patient Participation Group (PPG) who said they were very happy with the efforts the practice had taken to involve people in their care. The PPG met every quarter for a face-to face meeting in addition to the practice manager also having online discussions with the members on topics such as what surveys to undertake to gather patient feedback. Suggestions from the group, such as a change in appointment system to add telephone consultations had been acted on by the practice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Patients' needs were suitably assessed and met. Feedback from patients was obtained proactively and the service acted accordingly. The practice learnt from people's experiences, concerns and complaints to improve the quality of care. Arrangements had been made to help vulnerable people access care.

Responding to and meeting people's needs

The practice population has twice the national average of under 5s and half the national average of over 75s and about 40 percent of the patients belong to black and minority ethnic background. About 2000 patients on the list live in deprived areas including compact, isolated council estates. The services were planned and co-ordinated to ensure that patients needs were suitably assessed and met. The GPs told us that the practice ensured that frail and elderly people, people with mental health issues and young children were visited promptly at home.

The practice undertook regular medicine review for everyone on repeat medication. If patients happened to be also frail and elderly the practice would additionally review their risk of falls, home support and unmet needs. Dementia care was part of the local enhanced services (LES) (GPs are contracted to provide core (essential and additional) services to their patients. The extra services they can provide on top of these are called Enhanced Services. Local Enhanced Services (LES) are locally developed services designed to meet local health needs.) People with dementia received an annual medical review to ensure they were on appropriate medications.

The practice offered interpreter services and were able to have professional interpreter in person or by telephone or a family or friend interpreter present during the consultation.

The practice was fully accessible to the disabled, and all the patient areas including waiting room, consulting rooms and toilets had wheelchair access. Designated disabled parking space were also available.

Access to the service

There were a range of appointments available for people and these included telephone appointments, on the day appointments for urgent matters and pre-bookable appointments. Patients using the service could book appointments in person, or by telephone. A patient survey had been undertaken on extending the practice's opening hours. As a result the practice decided to open early rather than late evenings.

The practice also offered online services including ordering repeat medication and booking routine appointments. The practice participated in the Electronic Prescription Service which allowed for repeat prescriptions and increased choice as medications could be collected from other pharmacies if necessary.

The practice used South East London Doctors Cooperative (SELDOC) for out of hours care and this information was provided on a recorded telephone message, and on the practice website. The practice received an email communication by 8:00 a.m. the next day for patients attending SELDOC which was added to patients notes by reception.

The practice ensured that homeless people were registered with the practice. The GPs told us that they recognised the challenges associated in progressing care of homeless people and worked with one specific local charity to better able to meet their needs. The practice met the local charity on a two-monthly basis to discuss the social issues faced by the homeless people on its list and the support that could be provided. The practice in partnership with the charity provided food vouchers for people who qualified for receipt of emergency food. The practice had regular multi-disciplinary team (MDT) meetings and also quarterly liaison meetings with the community mental health teams to review the care of patients with complex needs.

Concerns and complaints

The practice had a complaints policy and procedure which was reviewed in May 2014. Information on how to make a complaint was included in the practice leaflets which were available in the practice as well as online. A poster on how to make complaints was displayed in the reception area. We looked at the practice's complaints register and saw that complaints were responded to in a timely and appropriate way. We saw the minutes of a complaint review meeting held in January 2014. There was evidence of analysis of the issue, along with shared learning and implementation of action. The practice manager reviewed the complaints and submitted an annual audit to the CCG.

Are services well-led?

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

Our findings

The practice was well-led and the culture within the practice was open and transparent. Risks to the effective delivery of service were assessed and there were suitable business continuity plans in place. Patients and Patient Participation Group (PPG) members told us that they felt listened to and involved in the decisions about the care. The staff were well supported and the receptionist team were a well-established team with long serving members. They worked closely together and felt able to raise concerns. Completed clinical audits had been undertaken.

Leadership and culture

A statement of purpose outlining the aims and objectives of the practice was available and also published on the practice website. All the staff we spoke with described the culture as supportive, open and transparent. The receptionists and all staff were encouraged to bring patients' concerns about their clinician to that clinician to ensure concerns could be promptly managed.

Staff we spoke with had been at the practice for many years, were proud of their work and team and we noted that the staff turnover was low.

Governance arrangements

The practice had robust governance arrangements and a clear management structure. The practice had weekly meetings which included partners meeting, clinical meeting (MDT) and practice meetings involving GPs, nurses, practice manager and receptionists. There were designated leads for specific areas of service delivery such as infection prevention and control and safeguarding. All the staff we spoke with were clear about who was responsible for making specific decisions. The GP partners had designated external roles as well which included one GP being the neighbourhood representative at the local CCG. The GPs told us of their leadership priorities which included collaboration and neighbourhood working with other practices.

Systems to monitor and improve quality and improvement

Incidents were reported promptly and analysed. Records showed that where applicable, practices and protocols had been amended as the result of leaning from incidents.

Audits were undertaken regularly, results discussed and shared with staff. The practice used the Quality and Outcomes Framework (QoF) to measure their performance at both a local and national level. The practice monitored and benchmarked their achievements with other local practices to ensure that they were providing suitable care to patients. Clinical procedures, such as immunisations, were audited and reviewed at a monthly intervals to ensure good practice and a high uptake which was 90 per cent currently.

Patient experience and involvement

The practice manager told us that the practice actively sought feedback from patients, carers and acted on their views. We spoke with two members of the Patient Participation Group (PPG) who said they were very happy with the efforts the practice had taken to involve people in their care. They said the practice listened to and responded positively to feedback. Suggestions from the group such as a change in appointment system to add telephone consultations had been acted upon. Patients we spoke with on the day of the inspection visit told us that they felt listened to and involved in the decisions about the care and treatment.

A patient survey had been undertaken on extending the practice's opening hours. As a result the practice decided to open early rather than late evenings.

Staff engagement and involvement

All of the staff we spoke with took pride in their work and felt well supported in their roles. We were shown recent examples where the practice had acted on its policy of rewarding high staff achievement by public acknowledgement at meetings or by e-mail. The whole practice also met together two or three times in a year for team building sessions. The practice was keen to feedback to all staff, especially receptionists, on practice performance. For example the practice had the highest percentage in Lewisham currently for people receiving NHS health checks. This was fed back to staff as they were closely involved in encouraging new patients to book for checks.

Learning and improvement

The practice had systems and processes to ensure all staff and the practice as a whole learnt from incidents and significant events to ensure improvement. Staff had individual objectives agreed at annual appraisal to help them with their professional development. The provider had a range of mechanisms in place such as review of complaints, and suggestions box to obtain feedback from

Are services well-led?

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

people using the service. The practice was adopting a planned approach of empowering nurses to manage long-term conditions with full support from the GP when required. The practice nurses had undergone training for this role.

Identification and management of risk

Risk management plans risk were place. Risks to the business continuity resulting from events such as IT equipment breakdown, inability of staff to reach work and flu pandemic had been identified and assessed, and plans had been put in place.

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

The practice undertook a formal medicine review consultation for everyone on repeat medication. For frail and elderly patients the practice would additionally review their risk of falls, home support and unmet needs. Dementia care was part of the local enhanced services (LES) and people with dementia received an annual medical review to ensure they were on appropriate medications. Patients over 75 were assigned a named GP to help continuity of care.

All the patients in this population group we spoke with said the service was responsive to their needs, and the comments we received were complimentary of the care and service that staff provided; although some patients commented about some difficulty in getting quick access to their GP of choice. The GPs told us the practice had a policy that frail and elderly people, when needed, were visited promptly at home. The practice had regular meetings with health and social care professionals to ensure that the care for people with complex health and social care needs was co-ordinated effectively. Patients and carers were involved in their care decisions and care was provided with respect to patients' privacy and dignity. In our observations we found the staff to be caring towards their patients. People received health checks, flu vaccinations and where applicable relevant health promotion advice.

All housebound patients got an annual visit for flu vaccination and staff would report any issues or unmet needs they found. The practice participated in the LES for end of life care and they liaised with St Christopher's Hospice who attended regular MDT meeting. Written notifications were provided to ambulance and out of hours service for patients near end of life.

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 practice was responsive to the needs of people with long term conditions (LTCs). Staff were well trained and had the knowledge and skills to respond to the needs of this population group and provide safe care to patients with cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD). The nurses were trained and able to provide care for conditions such as diabetes, COPD and asthma. The practice was responsive to patients' needs and undertook its own clinical tests such as spirometry for patients with asthma and COPD.

The care of patients with complex needs was reviewed at regular multi-disciplinary team (MDT) meetings. The practice was adopting a planned approach of empowering nurses to manage long-term conditions with full support from the GP when required. The practice nurses had undergone training for this role.

The practice undertook a risk profiling audit which helped in identifying relevant patients who would otherwise not be identified and miss out on support. We were given an example of a patient with multiple chronic diseases, who was not taking their medication regularly. As a result of this profiling the patient was identified, seen in practice, and provided additional advice and support to help improve their medication compliance.

The practice was responsive to people's needs. For example following withdrawal of locally available chiropody service, nurses underwent additional training on foot risk assessment so that patients did not have to travel far and could continue to access the service in the practice premises itself. To enable an efficient and more effective consultation patients with long term conditions were seen in general consultations, but offered longer double appointments where relevant.

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 followed national guidance, such as that provided by the National Institute for Health and Care Excellence (NICE) and staff were aware of their responsibilities and the various legal requirements in the delivery of care to people in this population group. There were multidisciplinary meetings and staff worked with other health and social care providers, including midwives and social care workers to provide a safe care.

The practice was responsive to the needs of the group and staff said calls involving young patients were given urgent priority. There were suitable safeguarding procedures in place. There were appropriate policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. Staff had received training on child protection which included Level 3 for GPs and nurses. The practice had a safeguarding lead who attended case conferences when able. Following a safeguarding course the practice created an alert on computer to audit "Accompanying adult" for children and it was now mandatory to log who accompanied each child with the purpose to increase the recording of the accompanying adult.

The practice had a named midwife from Lewisham Hospital available in the practice building and also shared care with Kings Hospital NHS Foundation Trust. The practice held weekly baby clinic to provide care and support to mothers with young babies. One of the GP partners had developed an infant attachment protocol that was given to new mothers and which we were told was very well received.

One of the GPs and the nurse were the designated leads for sexual health and for providing support and advice to patients requiring advice on 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 undertook a risk profiling audit which helped in identifying relevant patients, especially those with complex conditions, who would otherwise not be identified and miss out on support. There were a range of appointments available for people which included telephone appointments, on the day appointments for urgent matters and pre-bookable appointments. Patients using the service could book appointments in person, by telephone or on-line.

The practice nurses undertook cervical cytology, vaccination and immunisation, healthy lifestyle advice and health checks on new patients. The health care assistant (HCA) offered smoking cessation advice and patients were referred to them by the GPs. They received initial and continuing training to keep themselves up to date with current guidance. The practice had the highest percentage in Lewisham currently for NHS health checks. This was fed back to staff as they were closely involved in encouraging new patients to book for checks.

For out of hours care the practice used South East London Doctors Cooperative (SELDOC) and this information was provided on a recorded telephone message, and on the practice website. For patients attending SELDOC the practice received an email communication by 8:00 a.m. the next day which was added to patients notes by reception.

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 GPs and the practice manager told us that they worked with a specific local charity so that the homeless patients could get help with medicines, food and clothing. Vulnerable, homeless people were also referred to a food service partnership agreement for food vouchers.

People attending the practice were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing and staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

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

The practice had regular multi disciplinary team (MDT) meetings and also quarterly liaison meetings with the community mental health teams to review the care of patients with complex needs.

The practice used a variety of tools for diagnosing assessment status of patients with mental health issues. Based on this assessment patients were offered a tailored support including counselling (available from counsellor in practice), medication, or referral, all with on-going support.

The services were planned and co-ordinated to ensure that people's needs were suitably assessed and met. The practice found telephone consultations valuable for providing on-going support to people with mental health problems and when required also promptly visited people at their home.