Dr Kaushal Kishore Misra

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Kaushal Kishore Misra on 14 April 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be requires improvement for providing safe and well led services. It also requires improvement for providing services for older people, people with long-term conditions, families, children and young people, people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

The practice was good for providing effective, caring and responsive services. It was also good for providing services for working age people (including those recently retired and students).

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Some information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were available on the day they were requested and the practice offered telephone consultations and later appointments with the patient's named GP.
- Staff felt well supported by management and felt it was easy to raise any concerns.
- The practice had proactively sought feedback from patients and the patient participation group and had made changes as a result of feedback.

Summary of findings

- Some risks to patients were assessed and managed, however health and safety risk assessments including fire and infection control did not provide full assurance that risks were monitored.
- Adequate recruitment checks for valid professional registration were not in place.
- Data showed patient outcomes were average or above for the locality.
- Audits had been carried out that had improved patient outcomes, but not all audits were recorded to demonstrate improvements.
- The practice had a number of policies and procedures to govern activity, but some of these were three years old and had not been reviewed since.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.

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

Importantly, the provider must:

- Review and update infection control and cleaning procedures in the practice, including regular infection control and cleaning audits, secure disposal of clinical waste and control of substances hazardous to health.
- Ensure that staff are adequately updated in basic life support training, relevant to their role.
- Update the practice fire risk assessment and ensure staff have fire training at a relevant level, yearly or as required.
- Ensure there are robust systems to record and monitor medicines held in the practice including vaccines.
- Ensure that adequate checks for professional registration are carried out for new staff.

In addition the provider should:

- Identify risks to the practice through regular audit and risk assessments and maintain a risk log.
- Ensure that practice policies are regularly reviewed, updated and shared with staff.
- Ensure that there are robust incident reporting processes and all incidents and safety alerts are shared with practice staff.
- Ensure that the practice has effective safeguarding procedures, including systems to flag vulnerable adults and formal adult safeguarding training for staff relevant to their roles.
- Have assurances in place that criminal records checks are aligned with staff roles and are updated where necessary.
- Ensure that a programme of clinical audits reflect the needs of the practice and the audits are formally recorded to demonstrate improved outcomes for patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, lessons learned were not communicated widely enough to support improvement.

We found that the practice had not completed a recent infection control audit, so did not identify areas of weakness, such as furniture not being cleaned appropriately, inconsistent documentation in the cleaning log and risks related to the disposal of sharps. We also found the practice did not have appropriate fire arrangements in place such as an updated fire risk assessment and fire training for staff.

The monitoring of medicines was not robust. The practice did have access to medicines and equipment in the event of an emergency, however not all staff had received updated life support training.

A recruitment policy was in place; however the practice had not followed this and gained assurance of valid professional registration for a new member of staff. Safeguarding processes were satisfactory, however most staff had not received safeguarding adults training.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. We saw evidence to confirm that clinical guidelines and evidence based practice were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing at or above average for the locality. Patient's needs were assessed and care was planned and delivered in line with current legislation for all population groups. This included assessing capacity and promoting good health.

We saw that practice staff were very well informed about their patients' needs and actively sought to promote health checks and health promotion. The practice had robust processes for dealing with communications from other services and all test results and letters were dealt with within 24 hours by the patient's main GP.

The practice had performed particularly well for some targets, consistently achieving high levels for childhood immunisations.

Summary of findings

A number of clinical audits had taken place, however some were not always formally documented to demonstrate improved outcomes for patients.

Staff had received training appropriate to their roles and any further training needs had been identified and training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams for end of life care patients and for patients with complex needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff offered kind and compassionate care and worked to overcome obstacles in achieving this.

Data showed that patients rated the practice higher than others for several aspects of care. Patients described the service as excellent and said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG). The practice provided access to their services aligned with the needs of their population and recognised where vulnerable patients required further support to access its services.

Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with shared with staff and complaints were reviewed annually.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

Summary of findings

It had a vision but did not have a strategy or business plan in place. Staff were clear about their roles and responsibilities and there was some awareness of the vision for the practice. There was a leadership structure for some responsibilities, but it was not clear if all areas of the practice had a lead in place, for example for risk assessments. This resulted in risks not always being identified.

Staff felt supported by management and they knew who to approach with issues. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and not all policies were followed. Governance meetings were not routinely held but matters were discussed in three monthly staff meetings if needed.

The practice proactively sought feedback from patients and had an active patient participation group (PPG) and feedback was acted on. All staff had received inductions and appraisals and all staff attended staff meetings. Staff training needs were identified and most staff were given the training required, however some mandatory training had not been provided or was out of date.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The practice is also rated as requires improvement for being safe and well-led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over 75 had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and admission avoidance. It was responsive to the needs of older people, and offered home visits for frail and housebound patients and rapid access appointments for those with enhanced needs.

End of life care was discussed in multidisciplinary meetings with palliative care and district nursing teams and the practice was flexible in their approach to those with end of life care needs. The practice provided health promotion and screening services for the elderly population, such as a holistic needs assessment and signposting on to relevant services.

The practice had achieved highly in provision of the flu vaccination to over 65's and promoted the flu, pneumococcal and shingles vaccinations to older patients. The practice worked closely with a local pharmacy to highlight vulnerable older patients and ensure a cohesive approach to management of their needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The practice is also rated as requires improvement for being safe and well-led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

The practice had a higher than national incidence of some long term conditions such as diabetes. Nursing staff had lead roles in chronic disease management and the practice took part in a local initiative providing virtual clinics, where patients with complex needs were discussed with support from specialist services. The practice worked according to national guidelines for a number of long term conditions and had completed a clinical audit to measure its performance against best practice. There were robust systems in place to ensure that patients with long term conditions were

monitored and called in for reviews and annual health and medication checks. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice actively targeted patients in high risk groups to promote the flu vaccination and had achieved highly in this area. The practice worked closely with a local pharmacy to ensure that patients with complex needs were able to manage their conditions and highlighted where patients needed additional support. Longer appointments and home visits were available when needed and patients benefited from having consistency by seeing the same GP.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The practice is also rated as requires improvement for being safe and well-led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

There were systems in place to identify and follow up children who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were consistently high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. Baby clinics occurred weekly during suitable hours in the middle period of the day and the practice offered post natal examinations. The practice worked with midwives to deliver shared antenatal care. The health visitor team was based in the practice, which provided opportunities for concerns to be raised regarding children at risk.

The practice took part in the chlamydia screening enhanced service for those under 25 and this was actively promoted. Sexual health advice was offered by the practice.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). We found that the service was particularly effective, caring and responsive in relation to meeting the needs of this population group.

The majority of patients registered at the practice were those of working age and the needs of the working age population, those recently retired and students had been identified. Services offered

Summary of findings

had been aligned to ensure they were accessible, flexible and offered continuity of care. The practice was proactive in offering online services such as appointment booking, a virtual patient participation group, friends and family tests and the electronic repeat prescription request system.

A range of health advice was available on the practice website. Patients had a range of appointment options in order to have their health care needs met, such as access to lunch time telephone consultations daily and evening appointments with a GP or practice nurse on certain days, which were prioritised for working age patients. Pre-bookable appointments were also available. The practice were also able to direct patients to the extended hours services in the local area if required. The practice mainly used electronic prescribing so that a patient could collect a prescription from a pharmacy of their choice.

The practice provided the NHS health check for patients age 40-74 years and promoted a range of health promotion and screening services including in house smoking cessation, travel vaccinations, cervical screening, mammography and bowel cancer screening.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances make them vulnerable. The practice is also rated as requires improvement for being safe and well-led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

The practice had a large proportion of patients from a variety of ethnic backgrounds who did not speak English. The practice offered translation services but some staff were also able to speak languages to meet the needs of their population.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. It had carried out annual health checks for most people with a learning disability and offered longer appointments if required. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children, however not all staff had received training in safeguarding vulnerable adults. Staff were aware of their responsibilities regarding safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

The practice were aware of needs of patients acting as carers and benefited from a carers advisor once monthly in the practice. Patients could also self-refer to this service if required. The practice recognised the needs of homeless patients and had a policy where homeless patients could be registered with the practice.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The practice is also rated as requires improvement for being safe and well-led. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Patients were listed on a mental health register and the practice kept a register of patients diagnosed with dementia. Seventy one per cent of people experiencing poor mental health had received an annual physical health check and 89% of patients with dementia had received an annual review. The practice regularly worked with multi-disciplinary teams and specialist services in the case management of people experiencing poor mental health, including those with dementia. The clinical staff had a thorough understanding of the mental capacity act and when best interest decisions would need to be made.

The practice had an in house counsellor and psychologist and were able to refer patients to these services. It had a system in place to follow up all patients who had attended accident and emergency (A&E), including where they may have been experiencing poor mental health.

Longer appointments were available where necessary and home visits were available if required. Patients benefited from a consistent service by seeing the same GP.

Summary of findings

What people who use the service say

We spoke with 13 patients and reviewed 46 comments cards during the inspection. We looked at results from the GP patient survey for 2014 which had 79 responses and the patient participation group (PPG) survey for 2014 which had been completed by 96 patients.

We found that patients were strongly positive about their experiences at the practice and no significant concerns were identified. Patients said they felt the practice offered an excellent service, staff were polite, efficient, caring and they were treated with respect. Patients felt that they were provided with good quality care, they were listened to and had good continuity of care as they normally saw the same GP. A number of patients had been registered with the practice for a considerable length of time.

The majority of patients were happy with the appointment system and most could get an appointment the same day although some patients wanted the practice to open at weekends.

We spoke with three PPG members on the day and they felt the practice actively engaged with the PPG and acted on areas for improvement identified, such as improving access to telephone appointments and reducing waiting times.

Areas for improvement

Action the service MUST take to improve

- Review and update infection control and cleaning procedures in the practice, including regular infection control and cleaning audits, secure disposal of clinical waste and control of substances hazardous to health.
- Ensure that staff are adequately updated in basic life support training, relevant to their role.
- Update the practice fire risk assessment and ensure staff have fire training at a relevant level, yearly or as required.
- Ensure there are robust systems to record and monitor medicines held in the practice including vaccines.
- Ensure that adequate checks for professional registration are carried out for new staff.

Action the service SHOULD take to improve

- Identify risks to the practice through regular audit and risk assessments and maintain a risk log.
- Ensure that practice policies are regularly reviewed, updated and shared with staff.
- Ensure that there are robust incident reporting processes and all incidents and safety alerts are shared with practice staff.
- Ensure that the practice has effective safeguarding procedures, including systems to flag vulnerable adults and formal adult safeguarding training for staff relevant to their roles.
- Have assurances in place that criminal records checks are aligned with staff roles and are updated where necessary.
- Ensure that a programme of clinical audits reflect the needs of the practice and the audits are formally recorded to demonstrate improved outcomes for patients.

Dr Kaushal Kishore Misra

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP Specialist Advisor and an Expert By Experience. The GP Specialist Advisor and Expert By Experience were granted the same authority to enter Dr Kaushal Kishore Misra as the CQC inspector.

Background to Dr Kaushal Kishore Misra

Dr Kaushal Kishore Misra provides primary medical services from Borough Medical Centre in Southwark to approximately 2400 patients. The practice is part of Southwark Clinical Commissioning Group (CCG). Dr Kaushal Kishore Misra is one of 24 practices in the North Southwark CCG Locality. The practice area is in the fourth most deprived borough in England.

The practice population has a higher than national average representation of income deprived children and older people. The majority of the practice population is of working age; approximately 75% are aged 16-65. The practice population of people aged 65 and over is approximately 9.5%. Of patients registered with the practice, 25% are predominantly from a Bangladeshi background, 23% are from a White background and 13.7% from Black backgrounds.

The practice is registered as an individual GP provider and is located at Borough Medical Centre, which is shared with another GP who is registered separately with the CQC. The practice has ground floor ramped access. All consulting rooms and facilities are on the ground floor. The practices share some facilities such as the waiting room area, toilets, meeting rooms, staff room, however the clinical rooms and consultation rooms are not shared between practices. The practices do not share staff. Dr Kaushal Kishore Misra's practice team is made up of one male GP, one part time sessional male GP, a practice nurse, a practice manager, two reception staff and one administrative staff member. The practice is not a training practice for GPs.

The practice operates under a General Medical Services (GMS) contract, which is one of three main contracting routes a practice has with NHS England. The practice is signed up to a number of Enhanced Services (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice is also subscribed to the Quality and Outcomes Framework (QOF) which incentivise practice performance.

The practice reception and telephone lines are open from 8am to 6.30pm, Monday to Friday. Appointments are offered from 9am to12pm Monday to Friday. Appointments are available in the afternoon from 4.30pm to 7pm Monday and Thursday, 4pm to 6pm Tuesday and Friday and the practice is closed for appointments on Wednesday afternoons. The locum GP assists on a Monday afternoon and all day on Thursdays. Telephone access to reception is available during core hours and the GP provides telephone consultations after 12pm each day. The practice has an online appointment and repeat prescription request facility. Home visits are provided for patients who are housebound or are too ill to visit the practice.

The practice has opted out of providing out of hours (OOH) services to their own patients and directs patients to the out-of-hours provider. Since April 2015, the practice has taken part in a pilot project as part of Southwark CCG, directing patients to an extended access service within the locality which is open from 8am to 8pm, seven days a week.

Detailed findings

The practice directs patients to this service when it is not open for appointments, to provide wider choice of appointment times and more appointments for patients registered with the practice.

Dr Kaushal Kishore Misra is registered with the Care Quality Commission at Borough Medical Centre, to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

Why we carried out this inspection

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

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

We carried out an announced comprehensive inspection on 14 April 2015. During our visit we spoke with a range of staff including the GP, the locum GP, the practice manager, practice nurse, one reception staff and an administrative staff member. We spoke with 13 patients who used the service and three members of the practice's Patient Participation Group (PPG). We reviewed comment cards completed by 46 patients sharing their views and experiences of the service. We looked at a number of medical records.

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We received information from Southwark Healthwatch, which represents the patient voice. We also reviewed information from the GP Patient Survey for 2014 and reviewed the NHS choices website.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a limited range of information to identify risks and improve patient safety. For example, the practice demonstrated that they reported incidents and reviewed comments and complaints received from patients. All staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses using an incident form on the practice shared computer system. For example, we saw a significant event form related to an incident where a patient was requesting occupational health services from a GP. The practice was unable to provide these services to the patient under current NHS arrangements. As a result of this, the practice decided to direct future patients with questions about occupation health to the practice nurse, to allow a full discussion with the patient, to explain why occupational health services are not able to be provided.

We reviewed premises and equipment safety records including health and safety assessments, safety alerts and significant incident reports for the last two years. There was some evidence that the practice had assessed health and safety in the premises, however these assessments were not updated at structured intervals to provide assurances that risks had been identified and actioned. Minutes of meetings we reviewed over the last year did not discuss significant incidents, however the practice had a record of regular equipment safety records for the last few years. This demonstrated that there was some evidence that the practice had a safe track record over the long term, although improvements were required.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw the practice incident reporting policy which had been reviewed within the last 12 months. We were shown the process for incident reporting where the practice manger reviewed every significant incident form completed by staff and documented actions and outcomes.

There were three significant events that had occurred over the last 12 months recorded on the practice significant events log. One incident that had occurred recently was related to a urine sample being sent for the wrong test due to samples being placed in a generic area on the reception desk. The practice identified that the sample collection point required changing so that the area was clearly identifiable and planned that reception staff needed to educate patients where to place the samples for specific tests. Staff showed us during the inspection that these actions had been carried out and they felt the process for sample collection was much clearer for them and for patients. There was no completed significant event form for this incident to track, although it had been recorded on the practice log and the actions had been identified and completed.

We tracked two other significant events and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, such as referring patients to the practice nurse for a detailed explanation regarding occupational health issues where they arise.

Significant events were not a standing item on the practice meeting agenda. The practice advised us that significant events were discussed opportunistically with relevant staff or occasionally at staff meetings. Not all significant events were shared with all staff, for example clinical incidents were only discussed between GPs informally. We were told that the recent incident related to the urine sample collection point was to be discussed in the next staff meeting as it was relevant to all staff.

There was no evidence that the practice routinely disseminated national patient safety alerts to all practice staff or routinely discussed these; however we were told that they printed relevant patient safety alerts and medication alerts which were stored in a folder for clinical staff to review. Staff we spoke with were not able to recall recent patient safety alerts that had been shared in the practice. We did see posters relating to the Ebola alert in the waiting area.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a safeguarding adults and a child protection policy which had been regularly updated. We looked at training records which showed that all staff had received relevant role specific training in safeguarding children. However, from reviewing staff training records, only one member of staff had received training in safeguarding adults.

Requires improvement

Are services safe?

The lead GP was the appointed dedicated safeguarding lead for vulnerable adults and children. They had been trained appropriately in safeguarding children and could demonstrate they had the necessary knowledge to enable them to fulfil this role. The lead GP had not received formal safeguarding adults training, although the GP reported some safeguarding adults training had been received on an informal basis. All staff we spoke with were aware who the practice safeguarding lead was and who to speak with in the practice if they had a safeguarding concern.

We asked members of staff about their most recent training. Staff generally knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, including how to contact the relevant agencies in working hours and outside of normal hours. Contact details were easily accessible and visible in various areas around the practice.

There was a system to highlight vulnerable children on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice reported they did not use a system currently to flag vulnerable or at risk adults, however they reported that they were well informed with regards to vulnerable patients within their practice population. The practice did not have examples of regular liaison with partner organisations regarding safeguarding matters. The practice had not made any recent safeguarding referrals but they reported that if they had any concerns about children under five, as well as making a referral if needed, they could discuss these opportunistically with the health visitor on site.

There was a chaperone policy, which we saw on the practice shared drive, however this had last been updated in 2012. Signage advising that patients could have a chaperone was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) The practice nurse had been trained to be a chaperone. Nominated reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken either external or in-house chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The reception staff acting as chaperones had criminal records checks, however one reception staff member had a criminal records check when recruited eight years ago. The practice had no risk assessment in place in relation to chaperoning duties, to consider whether updated criminal records checks for non-clinical staff were required.

All staff had received information governance training and we saw evidence that patient records were stored securely. Records were either electronic, or stored securely in locked screened cabinets. The practice shared with us an information management risk log that identified information governance risks and an action plan from June 2014 and reported this is updated at regular intervals by an external information management contractor.

Medicines management

We checked emergency medicines stored in the treatment rooms and medicines in the refrigerator and found they were stored securely and were only accessible to authorised staff. Emergency medicines were also available in the doctors bag, however although this was kept securely, it was not locked and there was no key available.

There was a clear policy for ensuring that medicines such as vaccines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and we saw it was easily accessible to all staff and kept with the fridge temperature log records. We saw the log of minimum and maximum temperatures had been recorded daily and these were within the recommended range. The practice nurse and practice manager were able to discuss their roles and responsibilities with regards to any concerns they had with management of the cold chain for vaccines, and contact details and actions required were available in the event that any risks were identified.

Some processes were in place to check medicines were within their expiry date and suitable for use. The medicines kept in the fridge was rotated weekly by the practice nurse and we saw evidence that this check had occurred in the log record. The practice kept invoices of deliveries of medicines for the fridge. There were no records and no checks in place for the practice to show that the fridge medicines was audited on a regular basis and the practice told us that regular audit of fridge medicines did not occur. All the medicines we checked were within their expiry

dates. Expired and unwanted medicines were disposed of in line with waste regulations, however the practice used a hormone injection that requires disposal in a cytotoxic and cytostatic sharps container. The practice had standard sharps disposal containers available but the practice did not have a sharps disposal system specifically for cytotoxic and cytostatic sharps. The practice told us that they used very few of the sharps that require specific disposal, as only two or three injections were given every three months. The doctor disposed of these sharps in the correct sharps disposal system, in the pharmacy next to the practice. The practice did not have robust processes in place to show they had assessed the risks of sharps disposal and whether this was in line with guidance.

One of the GPs reported they attended six monthly prescribing meetings with the clinical commissioning group (CCG) pharmacist, where practice prescribing data was shared on a regular basis and targets were set. The practice also received the CCG newsletter, which set out local prescribing guidelines. The GPs discussed prescribing informally in the practice, for example first line antibiotic prescribing guidelines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We checked anonymised patient records which confirmed that the procedure was followed and medication was being prescribed appropriately. One GP discussed examples of patients on warfarin and whether different anticoagulation medication would be more appropriate, however it was deemed that in some cases warfarin was the safest option for patients. The practice discussed that they could not safely provide a repeat prescription of warfarin where patients had not been attending the necessary blood test appointments at the hospital, which are required before a prescription can be re-issued.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse had received appropriate training to administer vaccines, for example we saw a direction in place for the provision of the pneumococcal vaccine. We saw evidence in medical records that batch numbers and site of vaccines were consistently recorded.

The practice used electronic prescribing for patients as well as printed prescription forms. The practice told us they aim to use electronic prescribing where possible to reduce risk. All repeat prescriptions were reviewed and signed or authorised by a GP before they were re-issued to the patient. This was confirmed with clinical and non-clinical staff. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw that the blank forms were kept securely in a locked cupboard in a staff-only area of the practice, and we saw a register where boxes of prescription pads were signed out to be taken to the reception area, where they were also kept securely. Prescription pads in clinical rooms were kept securely. A prescription pad was also kept in the doctor's bag, that was stored in a locked room.

Cleanliness and infection control

The practice had an updated cleaning policy and schedule in place. We observed the premises to be clean and tidy in clinical areas. We spoke with a number of patients and they told us they always found the practice clean and had no concerns about cleanliness or infection control. However, we noted that the shared waiting room and patient toilets areas were not as clean as expected. There were fabric covered chairs in the waiting area and although these were scheduled to be vacuumed weekly, there were no further processes in place to ensure adequate infection and prevention control of this furniture. We noticed in the patient toilet area the pull cord for the light was visibly unclean and there were no assurances in place that this had been cleaned or changed.

Cleaning was carried out daily by an external contractor, and this was shared between the two practices in the premises. We reviewed the cleaning schedules in place and saw that cleaning records were sporadically kept. For example, the cleaning records had not been updated since February 2015, although they were to be completed on a daily basis. The practice told us they had not done any cleaning audits and the external contractor had not carried out cleaning audits.

Curtains in the consultation rooms were disposable and we saw they were clean and had been changed in February 2015.

The practice had a policy for the control of substances hazardous to health (COSHH), which stated clear

responsibilities for the practice around identifying which substances were used and how they were handled and stored. The practice had not followed this policy as they did not have a COSHH log or register in place to identify these substances.

We saw the practice had a waste management policy which had been updated in 2014, and the practice was disposing of most clinical waste in line with this policy, however the practice had not extended this to assess their sharps disposal to ensure this was in line with healthcare waste guidance.

The lead GP was the infection control lead for the practice, however they had not received more detailed training to enable them to provide advice on the practice infection control policy. All staff had received mandatory training about infection control specific to their role and received annual updates and staff training records verified this. The practice told us they did not carry out regular infection control audits internally or via external companies. We were shown an external infection control audit that was carried out by the local authority in 2012 and this had last been updated in 2013. Infection control was not routinely discussed in staff meetings.

An infection control policy and supporting procedures were available for staff to refer to on the shared drive and staff knew how to access these. The infection control policy had not been fully updated with information for the practice, and had last been reviewed in January 2014. We saw supporting policies such as the needlestick policy, hand hygiene policy and personal protective equipment policy. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms and toilets.

The practice had tested for legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice had a legionella risk assessment completed in October 2013 and no issues were identified. The practice did not have a schedule for re-testing in place or a policy for the management, testing and investigation of Legionella.

The practice had evidence of asbestos checks in 2012 and in 2015 and we saw certificates to demonstrate compliance with this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, which was in November 2014. Equipment included the ultrasound doppler, vaccine refrigerator, hearing loop and fans. We saw evidence of calibration of relevant equipment; for example the pulse oximeter, weighing scales, nebuliser, blood pressure measuring devices and the fridge thermometer.

Fire extinguishers were checked yearly, and the fire alarms, emergency lighting and panic alarms were checked six monthly. The external contractor invoices for all checks were shared with us from November 2014.

Staffing and recruitment

The practice had an up to date, thorough recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had a number of staff that had been employed for some years and one new member of staff had been employed since January 2015. Records we looked at contained evidence that most appropriate recruitment checks had been undertaken prior to employment for the new staff member. For example, proof of identification, references, qualifications and criminal records checks through the Disclosure and Barring Service (DBS). However, the practice had not followed their policy and obtained assurances of professional registration with the appropriate professional body. We saw a copy of an expired registration card from 2013. The staff member was registered to practice, but the practice had not obtained evidence of registration.

The practice employed a member of staff, who had been working at the practice for some time. The criminal records check for this staff member was completed in 2011, which was not instigated by the practice. At the time they started working for the practice, these checks were role specific and not portable between organisations. The practice did

not have a procedure in place to assess how frequently criminal records checks needed to be updated for permanent and sessional staff, dependent on their roles and responsibilities.

Staff told us about the arrangements for planning and monitoring the number of staff and reported that the mix of staff met patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and staff discussed with us the arrangements for covering sick leave.

All staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We were told that agency staff would be recruited in an emergency, if required.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, but were not regularly updated. The practice had a health and safety policy which had been updated in 2014. The practice had a premises risk assessment completed in 2012. A health and safety audit was undertaken by an external contractor in September 2013, who had also completed the practice fire risk assessment in 2013. The practice did not routinely carry out internal annual or monthly building and environmental checks. Equipment in the practice was checked on an annual basis, and the practice had a fixed electrical wiring check completed in 2013, which is required to be done every five years.

The practice had emergency buttons in consultation rooms and in the reception area. There was minimal health and safety information displayed for staff to see.

The practice did not keep a risk register or log of identified risks, however we were told these were known from previous health and safety audits that had been carried out. Risks were not routinely discussed within team meetings from minutes that we reviewed over the last 12 months. The practice told us that looking at guidance, they had decided not to carry our minor surgery as they did not have a defibrillator until recently. This risk discussion had not been formally documented in a risk assessment.

The practice did not have a formal policy in place for managing medical emergencies for high risk patient groups. However, we spoke to staff about how they would deal with medical emergencies and they were able to describe the steps they would take where health deteriorated suddenly, including alerting the GP and calling for an ambulance . Staff referred to some examples where an ambulance had been called for patients identified with deteriorating health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies, although improvements were required. Records showed that not all staff had received updated training in basic life support. Non-clinical staff received training every three years and some non-clinical staff had not had update training in line with practice policy. Clinical staff had received basic life support training which was updated every 18 months. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The emergency equipment was shared with the other GP practice in the same building, however it was checked by the practice manager. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Staff told us that they had never had a medical emergency in the practice.

Emergency medicines were available in secure clinical areas of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia and suspected bacterial meningitis. The practice did not have a documented risk assessment, to identify which emergency medications were considered appropriate for the practice stock. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We were told that the lead GP checked the emergency medicines on a six monthly basis. We reviewed a log that showed these were checked in April 2015, however there were no previous records available to demonstrate checks over time.

A business continuity plan was in place and up to date, to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included

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bomb alert, power failure including loss of the computer systems, failure of water supply, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed and information technology support numbers. The practice discussed how they had recently had to refer to the business continuity plan due to a recent bomb alert in the Bermondsey area. The practice had not needed to evacuate. Although risks were identified in the business continuity plan, the practice did not have a risk log to identify the level of risk.

The practice had carried out a fire risk assessment through an external contractor in September 2013. This had not been updated. Training records showed that only one new member of staff had received fire training. There were checks in place for all fire extinguishers and emergency lighting and we saw records showing these had occurred. The fire alarms were also checked six monthly by an external agency, and staff checked fire alarms weekly.

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Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told that the GPs opportunistically discussed new guidelines that were disseminated and the implications for the practice's performance and patients were considered.

We found from our discussions with the GPs and nursing staff that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, a GP discussed a patient where best practice guidance around anticoagulation medication was utilised to ensure risks to the patient were reduced to a safe level. We were also told that the practice followed NICE guidelines for chronic obstructive pulmonary disease (lung disease) and had completed an audit based on best practice guidelines for this condition. Another GP described how NICE guidance for heart failure was followed and we saw medical records to confirm that each patient received evidence-based treatment according to these guidelines. Other examples of NICE guidance that was being followed were guidance for long acting reversible contraception, diabetes, chronic kidney disease and NICE guidance around the use of vitamin D supplements. We saw detailed, thorough medical records confirming all these guidelines were adhered to.

Some medical records we reviewed were for patients who had multiple medical conditions, where a number of guidelines needed to be considered so patients received care and treatment that was tailored to their needs. We saw detailed problem lists, liaison with specialist services and routine reviews with the GP to update the patient needs assessment, in line with best practice.

The GPs were following guidance for end of life care by providing holistic case management for patients and their families. We were shown records of patients on the palliative care register at the practice and the detailed discussions involved related to their care. We saw a number of letters between the practice and hospital services demonstrating that end of life care guidance was being followed by considering patients' and families' needs in advanced care planning. We were also shown that patient preference was considered. For example, where patients declined to be on the palliative care register this was recognised, but they were included in palliative care meetings and their case management continued to follow end of life care guidance. We were shown how, when patients made improvements and no longer met criteria for end of life, they continued to receive support and contact from the GP, demonstrating that patients' needs were regularly re-assessed.

The practice used risk profiling to identify patients with the most complex needs. They had a register of high risk patients. From discussion and review of records, we saw that practice staff had a thorough overview of their most complex patients and use of coding on the electronic recording system for long term conditions assisted in prompting the staff to ensure these patients had a detailed needs assessment. We saw how administrative staff checked each long term condition register for the practice monthly, to ensure that these patients were called in for reviews and annual checks.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disease and asthma and the practice nurse supported this work through clinics. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice had signed up to local enhanced services, working in partnership with other practices as part of neighbourhood working. These enhanced services aimed to increase the identification of chronic obstructive pulmonary disease (COPD), dementia, diabetes and hypertension.

We were told that virtual clinics were held every quarter, which were multidisciplinary discussions for specific long term condition patients. The practice held virtual clinics for COPD to enable GPs to case discuss patients with the most complex needs with a respiratory consultant, pharmacist and nurse. The practice also held a virtual clinic for diabetic patients, to case discuss those with the most complex needs, for example where their diabetes was poorly controlled and the patients had difficulty managing their condition. The practice carried out annual health checks and care plans for patients with long term conditions, mental health conditions and elderly patients. The staff we

spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The practice held a mental health register of approximately 40 patients and had carried out a physical and mental health review yearly for 71% of these patients. The practice provided injections on a four weekly basis for stable schizophrenic patients and injections for dementia patients on a three monthly basis. We were shown medical records that confirmed this. The practice also had a register of patients with learning disabilities. There were currently three patients registered on this. We saw numerous examples of health checks for patients with diabetes, dementia and learning disabilities where an annual review template had been completed by the practice nurse and GP. A detailed care plan was normally completed by the practice nurse, but for some patients GPs tended to write action plans and care plans in the medical record.

Vulnerable older patients over the age of 80 had received a needs based care plan. Staff told us that they were working in partnership with a local integrated care service. We were shown an example of an integrated care assessment completed by the practice nurse, which identified a range of holistic needs and we were told that the practice referred on to other services where needs were identified. For example, where equipment was needed at home or if the patient was appropriate for an exercise referral scheme. The practice told us they had identified 38 patients appropriate for this assessment and had completed 50% of assessments which was below their target, as these were very detailed.

The practice had a process in place for reviewing patients who had attended accident and emergency (A and E), as part of the enhanced service for avoiding unplanned admissions. They identified frequent attendees and reasons for seeking emergency medical assistance. The practice manager or GP called the patient within three days of discharge and asked the patient to attend for an appointment. We were shown an example of a patient's notes where they were seen following an A and E attendance. The practice reported that they had frequent child attendees to A and E, due to the proximity of the hospital to the practice population.

The practice mainly used choose and book to refer patients to secondary care. We were shown data for the last six months, and on average 75% of referrals via choose and book were routine and 25% or referrals made were for urgent two week appointments. The practice did not have regular meetings to discuss referral rates internally, but did meet with the clinical commissioning group (CCG). We were told that the practice referral performance was average and they had been advised their urgent two week referral rate was lower than expected.

The lead GP told us that prescribing guidance was discussed during pharmacist meetings with CCG, and they were given targets, for example for antibiotic prescribing. Prescribing guidelines were also disseminated via the CCG bulletins.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. We saw records showing best practice treatment decisions for non-English speaking patients, and those with a learning disability and dementia.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. The practice demonstrated they had a strong grasp and knowledge of their patients and actively sought out patients requiring a medical review. From discussions with patients and GPs, we were told that complex patients' medical history and current problems were known in detail by their named GP. There was consistency for patients as they could see the same GP who monitored their conditions. Health checks were carried out by the practice nurse and GPs for those with long term conditions. These checks were regularly arranged by administrative staff.

Administrative staff had a key role in identifying patients due for a review or health check. We were shown how they monitored repeat prescription requests on a daily basis and used these as a trigger to check alerts on the electronic patient record system. These alerts highlighted where medical reviews such as blood pressure checks and annual assessments were required for each patient. Staff told us that they had been doing this for some time. Another

process for arranging patients for a review included checking all patients on each of the long term conditions registers held by the practice and calling them in where reviews were due.

The practice had processes in place to ensure new patients were monitored. If a patient had been registered for over a year and not attended the practice, the patients were called and invited in for a review if appropriate. When patients had attended for a review or annual health check, coding was used by all staff so that this information could be used to carry out clinical audits. Coding was also actively used to identify a range of long term conditions and vulnerable children.

The practice shared three clinical audits with us that had been undertaken in the last year. One of these was a completed audit for chronic obstructive pulmonary disease (COPD), where the practice was able to demonstrate the changes resulting since the initial audit. Other examples of audit included prescribing audits as part of the clinical commissioning group medicines management team. We were also shown a re-audit from 2012/13 related to blood glucose testing.

The COPD audit was undertaken in October 2014 by one of the GPs. The purpose of the audit was to compare the management of patients with COPD with local and national guidelines, including NICE guidelines. The audit specifically looked at performance of lung function tests, referrals for pulmonary rehabilitation and provision of the pneumococcal vaccine for practice patients diagnosed with COPD. The practice then re-audited the patient group after 3 months. The practice had 34 patients with COPD, which was 1.74% of the practice list size. From the initial review of patient notes, those who had not received lung measurement tests were contacted to perform these, 100% of patients had received the pneumococcal vaccination and further offers of pulmonary rehabilitation were made to suitable patients. The re-audit in January 2015 demonstrated that 100% of patients had received lung function testing and offers of referral to pulmonary rehabilitation had improved from 67.6% to 72.7% over the 3 month period. The findings of the audit were discussed in the practice staff meeting and we saw this documented in the meeting minutes. The findings were also shared with the virtual COPD clinic team. There was no plan in place to review the same audit the following year, however findings from this audit resulted in a further audit to look at inhaler prescriptions for these COPD patients, which was currently underway within the practice.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.) For example, we saw an audit from January 2015 which was part of the Southwark clinical commissioning group (CCG) medicines management team, prescribing incentive scheme. The purpose of the audit was to review the prescribing of pregablin for practice patients to see whether it was appropriate and in line with current neuropathic pain guidelines. The audit showed that the practice was the third best performer in the CCG for pregablin prescribing. All pregablin prescriptions had been initiated in secondary care, with appropriate prescribing as per local guidelines, as other methods of pain control had been tried first. The results of this audit were discussed with the GPs at the practice. There were no plans for the practice to repeat this audit internally, but they were to be guided by the CCG if a re-audit was required.

We were also shown another audit from January 2015, which was also at the request of the Southwark CCG medicines management team, prescribing incentive scheme. This audit was focussed on repeat prescribing behaviours of the practice, and how this linked to their repeat prescribing policy. The practice found that out of 57 items for repeat prescription reviewed, 100% had been prescribed appropriately and 96.5% of patients had received a medication review within 12 months. Actions identified by the practice were to update their policy with regards to a more formalised structure for medicines review, an information sheet for patients and update for staff. We saw evidence that these actions had been put in place as the process for contacting patients for a review had been streamlined and we saw that this had been discussed with staff in the most recent staff meeting in March 2015.

The clinical team were making use of clinical audit tools, informal clinical discussion and staff meetings to assess the performance of clinical staff. The GPs we spoke with

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discussed how they reflected on the outcomes being achieved and areas where this could be improved, but this was often informal discussion rather than structured meetings. Staff spoke positively about the culture in the practice around audit and quality improvement and the practice told us they were active in undertaking regular audits, such as a vitamin D audit that was started five years ago. This audit looked at the diagnosis and management of patients with vitamin D deficiency. Although staff were clearly able to articulate the rationale and improvements made for patients, a formal clinical audit had not been written up for this. The practice did not routinely discuss or put in place an audit plan for the year, as audits were identified on a more informal basis or were mandatory audits identified by the CCG.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Data for COPD and coronary heart disease were in line with national targets for 2013/14.

The practice told us that 8% of the practice population were on the diabetic register which is higher than the national average. The practice had provided an annual diabetic health check for 97% of patients on the register for 2014/15. The practice met all the minimum standards for QOF in diabetes and were higher than national average for diabetic foot checks and specific blood tests for diabetic patients.

QOF data for 2013/14 showed that 100% of patients diagnosed with dementia had been reviewed in a face-to-face review in the preceding 12 months and 89% had received a review for 2014/15. Patients who had received a mental health annual review and care plan was 71% for 2014/15.

The practice had achieved 100% for 2013/14 for prescribing an appropriate bone preservation agent for patients who had sustained an osteoporotic fracture. Prescribing data for 2013/14 showed that the practice was either within or below national targets for prescribing of hypnotics, anti-inflammatories and antibiotics. The practice was not an outlier for any QOF or other national clinical targets.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register of approximately 2% of the practice population. It held three monthly multidisciplinary meetings to discuss the care and support needs of patients and their families with the palliative care team.

The practice also participated in local benchmarking run by the CCG on a six monthly basis. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the practice was the third best performer in the CCG for pregablin prescribing.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were mostly up to date with attending mandatory courses such as safeguarding children, however the practice was having difficulty providing access to training for some staff for basic life support. One staff member had received fire training and one staff member had received formal safeguarding adults training.

The practice employed a sessional GP and a lead GP. We noted a range of skills among the two GPs with one having an additional diploma in cardiology and specific skills in joint injections. The GPs had protected learning time to attend training arranged by the clinical commissioning group, including paediatrics, obesity, end of life care, collaborative care planning and cardiovascular disease. None of the GP staff had specific update training in sexual and reproductive medicine. The GPs at the practice provided informal peer support and had discussions where needed regarding clinical matters, for example regarding management of patients with multiple long term conditions and cancer patients. We were told that the lead GP sought clinical support and peer discussion from the other GP practice on site, and regularly met with another local practice. We were told that the lead GP obtained clinical updates from educational sessions run at a private hospital in addition to local training. The lead GP also attended a yearly GP update course for evidence based practice.

Both GPs were up to date with their yearly continuing professional development requirements and both had been revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every

five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.)

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. The practice nurse had received annual training for immunisation and cervical cytology. The practice nurse did not have a peer support network locally with other practice nurses but had some informal contacts for support. The practice nurse sought clinical support from the lead GP where needed or via a previous colleague.

All staff undertook annual appraisals that identified learning needs from which personal development plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example information governance and read coding needs were identified for administrative staff. The GP practice does not currently act as a training practice for trainee GPs.

Working with colleagues and other services

The practice worked with many other service providers to meet patient's needs and manage those of patients with complex needs. The practice worked in partnership with a local integrated care service for elderly patients to identify where onward referrals were needed, for example for social services support, falls clinics and exercise referral schemes. Patients were often referred to voluntary services for additional support if they were isolated. The practice worked closely in the virtual clinics with a respiratory consultant and nurses and the virtual clinic case discussions were held at the practice. We were told that where carers were assessed and needs were identified, the practice referred to a local carers support service, who also ran sessions at the practice on a monthly basis. Practice staff were able to direct patients to self-refer to this service, or could raise any concerns to this support service opportunistically.

The practice benefited from access to a counselling service and psychologist on site and frequently signposted patients to these services. A health visitor team was housed at the practice and they used this opportunity to raise child protection and safeguarding concerns for those under five. However, the practice did not hold specific scheduled meetings with the health visitors. The practice worked closely with midwives to offer antenatal shared care. Checks were done at 25, 34 and 38 weeks by a GP or by a midwife and the practice liaised about the patients requiring checks, but the midwife did not routinely visit the practice.

The practice worked collaboratively with a local pharmacy next door. The practice and pharmacist worked opportunistically on a day to day basis to improve patient care. For example, the patients with complex needs were discussed so that housebound and frail elderly patients could have their medication delivered to them. We met with the pharmacist and they confirmed that they worked closely with the practice on a regular basis. The practice gave examples of patients with language difficulties who were not taking medication as prescribed. The practice worked with the pharmacist to change the number of medications and medication plan so it was easier for patients to manage their long term condition. This demonstrated that the practice worked with others to personalise care and treatment for patients.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. The patients on the palliative care register were discussed with the palliative care team every three months. The practice also aimed to meet monthly with district nurses to discuss patients with complex needs on their caseload. We saw minutes of meetings that confirmed these collaborative discussions, however the meetings were not always consistently held.

The practice was commissioned for the enhanced service, avoiding unplanned admissions, and had a process in place to follow up patients discharged from hospital to identify potential themes. The practice referred frequently to specialist services in secondary care and we saw regular correspondence in patient records to and from these services, for example from diabetes specialists and clinics.

The practice received blood test results, X ray results, and letters from local services, including hospital discharge summaries, out-of-hours GP services and the 111 service, both electronically and by post. The practice had clear responsibilities for all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GPs reviewed all letters from the hospital for their patients and were responsible for documenting comments in the electronic patient medical record. We were shown how the

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GPs reviewed all correspondence on the same day it was received and there were no outstanding letters to be filed or read. We found that the workflow process for reviewing results was very robust. We saw that all results received were reviewed by the named GP and actioned on the same day. There were no outstanding results requiring a review. We were told that only in extenuating circumstances would GPs review each others patients' results and every effort was made to ensure this system was followed.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

Information sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and we were told the practice mainly used choose and book for its referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.) Staff reported that this system was easy to use and they felt it gave them more assurances that referrals were not missed.

The practice used an electronic prescription service to communicate with local pharmacies. The practice reported that the majority of prescriptions were submitted electronically, which GPs felt was a much safer method for the practice.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice had also signed up to the electronic Summary Care Record and this was fully operational. We saw advertisement of the summary care record in the practice waiting area and information was on the practice website for patients. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Staff had received recent read code training to ensure they could use the system effectively. Staff had defined roles and responsibilities using this system to ensure information was processed effectively and efficiently. Read coding was used appropriately in the practice and we saw numerous examples of how coding was used and alerts raised, for example where a blood pressure check was due for a patient. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff showed us how faxed and paper letters received were scanned immediately onto the system and then the paper copies were left for the doctor to review. We saw evidence that administrative staff checked all letters received on a monthly basis against the electronic system to ensure they had been scanned. Using this process the practice had not identified any incidents where letters had not been scanned onto the system.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs had received some informal training through the clinical commissioning group learning opportunities for the Mental Capacity Act. For specific scenarios where capacity to make decisions was an issue for patients, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. For example, a GP shared with us a medical record for an adult patient with a learning disability who was unable to consent to treatment. Best interest decisions were made, which also considered parental wishes. We were told about a patient who needed urgent medical attention but was refusing to go to hospital, however the GP assessed that the patient did not have capacity to make this decision and the patient was admitted to hospital. The GP spent considerable time at the patient's home liaising with the patient, family and emergency services in order to make this best interests decision.

Patients with a learning disability and those with dementia were supported to make decisions through the use of health review templates and care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical

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circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. We were shown an annual review for a patient with dementia and their family, where advice was provided to family members on enabling the patient to make decisions where possible for a range of needs.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.)

There was a practice policy for documenting consent for specific interventions. For example, for joint injections, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the CCG to discuss and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. Eighty four per cent of newly registered patients had received a health check in 2014/15. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing and there was a common approach amongst all staff to use the alerts on the electronic patient record to actively promote health checks and reviews. Clinical staff promoted health screening and health promotion to patients opportunistically, for example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. We saw medical records where diabetes checks had been completed and patients were given weight management and exercise advice.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. These health checks were completed every 5 years. Practice data showed that the practice had a target for 2014/15 of health checks for 89 patients with the practice nurse, but had exceeded this target and completed 138 health checks over the last 12 months. The practice nurse showed us how patients were followed up by a GP if they had risk factors for diseases identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all had been offered an annual physical health check. Practice records showed that two of these patients, had received a check up in the last 12 months. Diabetic patients, dementia patients and those on the mental health register were also entitled to annual reviews.

The practice demonstrated they actively targeted those who smoked to attend smoking cessation one-to-one support and advice with the practice nurse, which was tailored to the patient. The practice had identified the smoking status of 88% of patients over the age of 16 and 100% had been actively offered the nurse-led smoking cessation clinic. There was evidence this in-house clinic was having some success as the number of patients who had stopped smoking in the last 12 months was 50% of those referred which was above average compared to neighbouring practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. The practice kept a register of obese patients and weight management advice was documented in medical notes. These patients were offered a referral to an exercise scheme in Southwark. The practice had also recorded alcohol status for 99% of patients over 16 for 2014/15. Fifty four patients had received a full alcohol assessment, which was 98% of eligible patients. Fifty two per cent of these received brief intervention from the practice and two patients were referred on for further detox programmes.

The practice had been actively promoting the uptake of seasonal flu vaccinations. For example, as well as opportunistic flu vaccinations, they printed flu reminders on prescriptions, and had visual advertisement on the practice website. The practice sent text message alerts in

Good

Are services effective?

(for example, treatment is effective)

two cohorts during the autumn and winter season for each eligible patient, but also called patients that were particularly vulnerable. The practice had provided the enhanced services for the pneumonia and singles vaccinations for those that were eligible.

For 2014/15 the practice had achieved all the targets for flu vaccinations and were at or above CCG average. The practice vaccinated 78% of eligible people over 65 years. For the patient group at risk aged 6 months to 64 years, the practice vaccinated 67% of this population group, which was one of the highest in the CCG. For 2013/14 the practice had again performed above the national average, vaccinating approximately 68% of the at risk group. For pregnant women, 75% of eligible patients had been vaccinated in 2014/15. The shingles vaccination programme had been offered as an enhanced service for 2014/15 and 55% had received this, as some patients had declined.

The practice actively promoted bowel screening, mammography and cervical screening. Alerts had been set up on the electronic patient record for eligible patients so all staff were able to remind and promote this opportunistically to patients, and they contacted patients who did not attend. The practice's performance for cervical smear uptake was 84% for 2013/14, which was better than the national average. Performance for 2014/15 was 81% which was the same as the national average but better than the CCG average of 71.2%. Uptake of mammography was 47.1% which was below the CCG average of 60.5%. Bowel cancer screening uptake was 27.3% which was below the CCG average of 42.1%. We did not see any information promoting bowel and breast cancer screening in the practice.

The practice offered sexual health advice mainly through the practice nurse but also opportunistically via GPs and the practice referred patients to the sexual health clinic. The practice found that due to cultural issues and language barriers, raising awareness of sexual health advice and screening often proved difficult for them. The practice took part in the Chlamydia screening enhanced service for those under 25. The reception team used electronic flagging and provided testing kits. The practice had a target of 35% for 2014/15, however the uptake was 26% of the target population. We saw some sexual health promotion posters in the practice.

The practice offered a full range of immunisations for children and travel vaccines in line with current national guidance. The practice was not a yellow fever centre. Performance for all childhood immunisations for those aged 12 months, 24 months and five years for 2013/14 was well above average for the CCG. For the five in one vaccine and PCV vaccine, 100% of patients under 12 months had received the vaccinations compared with the CCG average of 91.1% . Data for 2014/15 for the five in one and PCV vaccination also demonstrated high performance in this area, with the practice again vaccinating 100% of eligible patients. Patients who had received the pre-school booster for 2014/15 was 100% which was way above the CCG average. The practice had a robust processes for ensuring patients were reminded to attend for vaccination and followed up non-attenders by using alerts on the electronic patient record system. The practice nurse completed the patient red books with details of when the vaccinations were due. The practice performed monthly searches to identify patients who were due for vaccinations in order to improve uptake.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from 79 responses from the GP patient survey for 2014, a survey of 96 patients undertaken by the practice's patient participation group (PPG) in 2014, and recent friends and family test (FFT) data for 2015.

The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that 83% describe their overall experience of the surgery as good. Ninety two per cent of patients had confidence and trust in the last GP they saw or spoke to and 100% had confidence and trust in the last nurse they saw or spoke to.

The practice was satisfactory in relation to its consultations with doctors with 76% of practice respondents saying the last GP they saw was good at listening to them and 78% saying their GP gave them enough time. However, 68% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, which was below the CCG average of 80%. Ninety one per cent of patients reported that the last nurse they saw treated them with care and concern. The FFT data for February 2015 showed that 84% of patients were either "extremely likely" or "likely" to recommend the practice. Data from the FFT each month were at a similar level.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 46 completed cards and the majority were very positive about the service experienced. Patients said they felt the practice offered an excellent service, staff were polite, efficient, and caring and they were treated as individuals and with respect. We saw a number of comments that were complimentary about the care received from the GPs and described one GP as an "exceptional doctor" and that the GP always met their needs. Patients told us that they had been registered for a number of years with the practice due to the service they received. A number of patients had been registered with the practice for more than 30 years. Five comments were less positive but there were no common themes to these.

We also spoke with 13 patients on the day of our inspection. Most patients told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

The practice reception area was shared between the two practices in the building, so that phone calls would be occurring in close proximity for both practices. The reception area was not shielded with partitions from the waiting area so there was a risk that patient conversations could be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments on the phone or face to face so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There were no instances where staff had witnessed unprofessional behaviour and we found that staff were acting with dignity and respect when making and receiving calls and conversing with patients in the waiting area.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour and we saw a policy on the practice's shared computer drive that was accessible for staff. Staff gave examples of situations where patients had acted in a difficult manner and referring to this had helped them diffuse these situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients had mixed responses to questions about their involvement in planning and making decisions about their care and treatment, but generally rated the practice well in these areas.

Good

Are services caring?

For example, data from the GP patient survey showed that 74% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments, which was slightly lower than the CCG average of 83%. However, only 64% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care, which was below the CCG average of 77%

Patients were positive about experiences with the practice nursing service; 89% said the last nurse they saw or spoke to was good at involving them in decisions about their care and 90% said the last nurse they saw or spoke to was good at explaining tests and treatments.

The results from the practice's own satisfaction survey from 2014 showed that 90% of patients said that their treatment was explained to them and described it as either good, very good or excellent.

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

Staff told us that due to the predominant Bangladeshi population registered with the practice, they did face difficulties with language barriers. We were told that telephone translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The lead GP was able to communicate with most patients as he spoke two other languages and a non-clinical staff member was also able to speak another language. The practice also encouraged family members to act as translators where appropriate.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of respondents to the Patient Participant Group survey in 2014 said that they were supported to express their concerns and fears to medical staff. Ninety three per cent said they had received help to access support services to assist them to manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the CQC comments cards we received were also consistent with this survey information, as they felt that the staff were very supportive to their emotional needs. This highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, leaflets available and the practice website advised patients how to access a number of groups and organisations such as victim support. The practice had access to carers support once monthly and were able to refer directly to this service where needed.

Staff told us that they were sensitive to the additional needs of carers and tried to support them as much as possible, where identified. The practice did not routinely use a register to alert them to patients that were also carers.

Staff told us that if families had suffered a bereavement, their usual GP contacted them and arranged an appointment if required, to meet the family's needs and by giving them advice on how to find a support service. The practice staff also utilised the in-house counselling service that was available twice weekly, and were able to refer patients directly where indicated. There were notices in the practice alerting patients to the in-house counsellor. We did not see any patient information in the waiting area about bereavement support available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice told us that the lead GP met with the Clinical Commissioning Group (CCG) locality for North Southwark on a monthly basis. Patient needs and themes were discussed to identify where the practices in the locality needed to make service improvements. For example, needs had been identified to improve extended access in the locality area and a new extended access clinic was set up nearby. The practice had minutes of staff meetings where this scheme was discussed with all staff and the benefits to practice patients were identified, where patients could not access an emergency appointment at the practice.

The practice had also identified the need to improve integrated care for the elderly practice population. They were part of a neighbourhood network of practices completing a local integrated care holistic assessment for patients, and signposted them to the appropriate health and social care services as a result of the assessment. We saw minutes of two staff meetings where this had been discussed with all staff members and progress was captured.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and the patient satisfaction survey for 2014. We saw the PPG report for 2014/15 which discussed the key priorities identified from this survey.

The practice found that there was some dissatisfaction with the appointment system and they identified that they needed to provide a more flexible service. The practice told us that this had been challenging as there was one full time GP and a part time sessional GP employed, however they made changes within the resources available. The practice changed appointments so there was access to lunch time telephone triage appointments for those requesting an appointment the same day where appointments were fully booked, or for patients who were unable to visit the surgery such as those of working age. The practice also changed appointments so that routine appointments could be booked ahead of time and they promoted the online appointment system.

Tackling inequity and promoting equality

The premises and services had been adapted to meet the needs of patient with disabilities. The practice had ramped access and all clinics and consultation rooms were on the ground floor. We saw that the practice waiting area was large enough to accommodate wheelchairs and pushchairs. The practice also provided a hearing loop for patients with hearing difficulties. There were accessible toilet facilities for all patients attending the practice. Baby changing facilities were available, however we noted that the baby changing facility was provided in a corridor of the practice due to limited space in the toilet for this.

The practice had recognised the needs of different groups in the planning of its services. For example, a large proportion of patients did not speak English. Twenty five per cent of the practice population were Bangladeshi patients, however we were told that one GP and one reception staff member were able to speak three languages including Bengali. The practice advised patients ahead of the appointment to bring a family member to assist in translation if the patient agreed. One administrative staff member showed us the information about the translation service and gave examples of when this was used. We saw notices in the waiting area to advise patients that a translation service was available.

The practice recognised that they needed to accommodate homeless patients and travellers, and although they did not have any patients registered, they have had homeless patients registered in the past. We were told how the practice would use their address to register these patients.

The practice recognised that they needed to prioritise vulnerable patients when booking appointments. For example, reception staff told us that if a child or older person was unwell and needed an urgent appointment, these patients would be seen over the lunch time period or before scheduled appointments began, in emergency slots. We were shown how electronic flagging assisted with identifying patients with varying needs, such as vulnerable

Good

Are services responsive to people's needs?

(for example, to feedback?)

children, those with learning disabilities, long term conditions and dementia. This enabled staff to book double appointments if required, so their additional needs could be addressed.

The practice told us they worked with the next door pharmacy to ensure vulnerable patients were monitored and they were managing medications. For example the pharmacist had given feedback to GPs when visiting housebound patients to deliver their medication, where concerns were identified.

The practice reported they recognised the needs of patients acting as carers. For example, they had access to a carer's advisor in the practice on a monthly basis. The practice were able to refer directly to this service when support for carers was required. The carers advisor had also worked with carers to ensure training and support was delivered through the practice to meet their needs.

Practice staff had not received equality and diversity training, however staff understanding of promoting equality and valuing diversity was evident from discussions with staff and through review of practice meeting minutes and patient participation group minutes, where a range of patient needs were routinely discussed. We were given examples of systems in place to contact patients with mental health needs who did not attend their appointments. We were told that the reception staff were educated about patients' vulnerability and were aware of the need to contact them to encourage them to attend, so they received their treatment.

The PPG had representation from a mix of ethnic backgrounds including British, Irish, Indian, Bangladeshi and African to ensure a range of views were represented. Staff told us that they had considerable difficulty recruiting to the PPG due to language barriers, so they did not get full representation of patient voices from different ethnic backgrounds.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday for telephone and walk in access. Appointments were available from 9am to 12pm on weekday mornings. Appointments were available in the afternoon from 4.30pm to 7pm Monday and Thursday, 4pm to 6pm Tuesday and Friday and was closed for appointments Wednesday afternoons for staff training and meetings. The doctors provided telephone consultations after 12pm each day and home visits in the afternoons if needed.

The practiced offered pre-bookable appointments with a GP and also held approximately 36% for same day appointments and emergencies. Appointments between 6.30pm and 7pm were only bookable in advance and were normally provided for patients who worked during the day.

A number of staff told us that during the times that appointments were not available, the urgency of the patient need was triaged by a GP on the telephone. If the patient needed a same day appointment, the GP would see the patient before the bookable appointment times in the afternoon, or would add them to the clinic list. The practice was flexible in its approach to urgent appointments. If patients needed urgent appointments on a Wednesday afternoon when the practice was closed, a GP would provide telephone triage and accommodate patients where appointments were deemed urgent. Reception and administrative staff told us it was practice policy that the GPs would try to meet the needs of any urgent patients on the same day, even if the appointment capacity had been reached. The GPs told us that they knew their patients in detail and felt it was more efficient for the patient as well as the practice to see urgent patients themselves, rather than directing them to a walk in centre where their holistic needs may not be known.

Where the practice had reached capacity and were unable to offer same day appointments, or if the patient preferred to access an alternative service, they were able to direct patients to an extended access service. From April 2015, the practice joined in a pilot project with neighbouring locality practices, directing patients to an extended access service at local medical centre which was open from 8am to 8pm, seven days a week. We were told that this provided a wider choice of location, appointment times and more appointments for patients registered with the practice.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. After operational hours, the practice directed patients to seek medical assistance from the out-of-hours provider, which was accessed via a telephone number displayed on the practice website and via the practice answerphone

message. Information advertising this service was also displayed in the practice and on the practice leaflet. Patients were directed to 111 if it was not a medical emergency.

The practice offered pre-bookable appointments for mother and baby clinics, health checks for long term conditions, travel vaccinations, child health surveillance and childhood immunisations with the practice nurse. Appointments with the practice nurse were available during extended hours on Monday and Thursday evenings, for example for cervical screening for working age patients. Pre-bookable appointments were also available one morning per week with the psychologist and a counsellor. The practice used text messages to remind some patients about clinics and appointments, for example patients eligible for the flu vaccination.

Home visit were provided for patients who were housebound or too ill to visit the practice, especially frail elderly patients and those with long term conditions. Doctors told us that they normally undertook around three home visits per week. Longer appointments were available for patients who needed them such as those with long-term conditions and learning disabilities. The practice also recognised that it had a large percentage of families and working age patients, and offered combined family appointments where necessary, for example, we spoke with a parent who had brought two children for a joint appointment.

We saw comprehensive information was available about appointments and clinics offered on the practice website and practice information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice also provided an online repeat prescription request facility.

Patients were generally satisfied with the appointments system. The GP patient survey for 2014 found that 90% of respondents found it easy to get through to this surgery by phone which was above the clinical commissioning group (CCG) average of 75%. Eighty six per cent of respondents were satisfied with the surgery's opening hours which was above the CCG average of 75%. Sixty eight per cent of respondents with a preferred GP usually got to see or speak to that GP, compared with the CCG average of 53%. Patients we spoke with commented that they found it easy to book an appointment.

Patients we spoke with were happy with the appointment system on the whole. One patient stated that they had always been seen by a GP on the same day in case of an emergency and patients were very positive about being able to see the same GP consistently. Two patients we spoke with had been booked in for emergency appointments. Another patient we spoke with, who had long term conditions, reported that they were often late for appointments and the surgery always accommodated them.

Feedback from some patients we spoke with, CQC comments cards and the patient satisfaction survey in 2014 identified that patients would like access to weekend appointments at the surgery.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system such as information in the practice leaflet and notices in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received two complaints over the last 12 months. The practice kept a complaints log as well as a complaints folder. We looked at the two written complaints received and found that one patient had complained about the appointment booking system and reception staff. We saw that the practice had sent a written apology in a timely manner and were transparent about issues that had triggered the complaint. We saw a detailed root cause analysis which tracked the events associated with the complaint, which included interviewing staff members involved. As a result of this, the practice had identified further training needs for reception and administrative staff around conflict resolution and communication. We were shown actions that the practice had put in place, which included a specific folder in the shared drive accessible to all staff which contained the zero tolerance policy, information about customer care and conflict resolution for staff to read and links to online training for staff to

Good

Are services responsive to people's needs?

(for example, to feedback?)

complete. We were also told that the practice were arranging additional face to face training for conflict resolution. This demonstrated that the practice were actively trying to improve according to feedback from complaints.

A second complaint was related to the use of the electronic prescribing system. The patient concerned was telephoned and did not receive a written response from the practice. The practice told us that this was because the complaint was dealt with in a timely fashion and resolved quickly.

The practice reviewed complaints annually to detect themes or trends. We looked at minutes of a staff meeting where these annual complaint themes were discussed with all staff and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care, treat patients with courtesy and consideration and promote good outcomes for patients, and this was laid out in the practice information leaflet as rights and responsibilities for the practice. We were told that the purpose of the practice was to provide people registered, with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. They said they aimed to achieve this by developing and maintaining a happy, sound practice which is responsive to people's needs and expectations and which reflects whenever possible the latest advances in Primary Health Care. The practice did not have a strategy or business plan in place to detail the vision and values of the practice further, but they had the information accessible in the Statement of Purpose in the practice shared computer drive. The vision and values were not displayed in patient areas.

We spoke with six members of staff who were able to articulate their interpretation of the values of the practice, they knew and understood the practice rights and responsibilities and were aware of their roles in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on in the shared drive on any computer within the practice. Staff showed us how to access these policies should they need them. We looked at 11 of these policies and procedures. Policies included the practice zero tolerance policy, the incident management procedure, the practice chaperoning policy, the child safeguarding policy, the confidentiality policy and the health and safety policy. We also noted that the practice had policies relating to infection control such as the main infection control policy, the needlestick injury policy, the hand hygiene policy, the Control Of Substances Hazardous to Health policy and the waste management policy.

We saw that the practice had an employee handbook in the shared computer drive and an Induction pack for new staff to indicate which policies to read. We were told that when policies were updated, staff were alerted informally but the practice did not get staff to document that they had reviewed the updated policies. There was no clear structure to indicate when policies would be updated. We saw that some policies had been updated annually, such as the health and safety policy, the waste management policy, and the safeguarding children's policy. We noted that other policies had not been updated for some time, such as the hand hygiene policy and chaperoning policy which were last reviewed in 2012 and a number of other policies had been reviewed over a year ago.

Not all policies contained detail about key areas and we noted that not all policies were followed. For example, the infection control policy had no information about how infection control would be monitored and audited in the practice and some areas of the policy had not been fully completed such as the details about infection control training and the health protection unit contact details. The policy was last updated in January 2014, but it was documented in the policy that it was to be reviewed at least annually.

There was a leadership structure with main GP being the lead for a number of areas of the practice such as infection control and safeguarding adults and children. It was not clear who the health and safety lead was for the practice or if the practice had a fire co-ordinator. However, we spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data and locally agreed service targets was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, the integrated care service assessment targets for older patients and updates regarding the diabetic and chronic obstructive pulmonary disease virtual clinics had been discussed at staff meetings. The practice also had meetings six monthly with the clinical commissioning group (CCG) to discuss performance in comparison with other practices in the area.

The practice had completed some clinical audits which it used to monitor quality for patients but it did not have a clear programme of on-going clinical audits or systems to identify where action should be taken and where audits

Are services well-led?

Requires improvement

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

should be targeted. Audits were often initiated by the CCG in relation to prescribing data. Some audits were initialised by the practice but were not all formally recorded to demonstrate service improvements.

The practice had limited arrangements for identifying, recording and managing risks. There was no risk register or log in place and risks were not regularly discussed in team meetings. Risk assessments had been carried out previously, but these were by external companies. For example, the premises infection control risk assessment in 2013, and the health and safety and fire risk assessments in 2013. No internal risk assessments had been completed.

The practice carried out an annual information management risk assessment by an information technology trainer and we saw that this had last occurred in June 2014. The practice had ensured that all staff had received updated information governance training as a result of this assessment. We saw minutes of meetings where information governance had been discussed.

The practice did not hold formal governance meetings looking at performance, quality and risks. These issues were discussed where indicated in practice staff meetings every three months, or opportunistically with staff where issues arose. Complaints were reviewed annually in the staff meeting with all staff present, to look for patterns and themes in complaints received.

We noted there were some blurring of boundaries between the two practices that operated in the same premises. We heard from staff that the practice manager was frequently asked to support the other practice in terms of day to day matters and queries. There appeared to be lack of leadership in certain areas such as infection control, and poor oversight with shared responsibilities such as building and environmental risk assessments including infection control and cleaning audits. The practices did not have a cohesive approach in response to these responsibilities and there was limited evidence of sharing of information and planning between the two practices.

Leadership, openness and transparency

We saw from minutes that team meetings were held every three months. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings, day to day and in appraisals. We were told that the practice did not arrange team away days or team building exercises.

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the Friends and Family Test (FFT), patient participation group (PPG) surveys, reviews of complaints, reviews of actions taken in conjunction with the next year priorities, NHS choices feedback and PPG meetings with patients. The FFT was also accessible online for patients to complete.

The PPG survey for 2013/14 was carried out in January 2014, with 120 questionnaires being given to patients and 96 responses were obtained, which was a return rate of 80%. The results were collated and analysed by an external company. The PPG survey had identified two main areas for action, which were discussed in February 2014 and these actions were looked into by the practice and PPG over the next year. The two areas for action were: reducing waiting times and improving access to a GP within 48 hours. The practice implemented a change in the appointment system, by offering telephone appointments over the lunchtime period and raising awareness of these appointments.

The practice had an active patient participation group (PPG) of 5 patients, with 15 patients registered with the PPG and they met every three months. The PPG had representation from a mix of ethnic backgrounds including British, Irish, Indian, Bangladeshi and African to ensure a range of views were represented, however they had difficulty recruiting younger patients. The PPG report detailed how it promoted meetings, for example, via messages on prescription forms, advertising in the waiting area and face to face discussions in the practice, including PPG information in the new patient information pack and handing out leaflets at clinics. Practice staff told us that they had tried numerous methods of recruiting patients to the PPG, however they were unable to improve PPG numbers due to the practice population being mainly non-English speaking, and having a large number of

Are services well-led?

Requires improvement

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

patients of working age. The practice had developed a section of the website for the PPG and recruited 'virtual' members to aim to improve PPG numbers, providing an online alternative to make suggestions, comments and review PPG minutes. We saw evidence from minutes of PPG meetings, the annual PPG report, speaking with staff and PPG members that the practice recognised PPG numbers were low, and it was actively trying to promote the group, within resources available.

We saw minutes of meetings that showed five PPG meetings had been held within the last year. The practice produced an annual PPG report for 2014/15 and we saw in the report that the PPG had identified priorities for improvement from the annual patient survey and discussed progress with these priorities. Priorities included improved access to telephone appointments with the GP. There had been a 3% improvement since 2013/14 with the initiation of on the day telephone appointments at lunchtime. The survey also identified the need for improved access to GP appointments, so the practice had promoted online services and pre-bookable appointments two weeks ahead. The PPG identified a priority to create the practice website to improve online access to appointments and information sharing for patients. The practice successfully implemented the practice website over the last year.

The practice had gathered feedback from staff through appraisals and staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients and most staff had worked at the practice for some time. Staff felt that they were very supported by the practice manager and by the GPs for day to day issues. The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice and we were shown how staff could access this.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at seven staff files and saw that regular appraisals took place which included a personal development plan.

The practice did not keep a formal training schedule or policy but kept training details for staff in a training log and in individual staff records. Staff told us that they felt the practice was supportive of training. The GPs had opportunities weekly to attend clinical commissioning group (CCG) training during their protected learning time and we saw the training log that detailed recent training updates for both GPs. The lead GP attended a yearly GP update in evidence based best practice. Administrative staff also received training such as recent training in using coding on the computer system, so it was used more effectively.

The practice nurse did not receive support from other practices or a structured peer review. Where needed the practice nurse sought clinical support from the lead GP, and had some details of previous colleagues that could provide support. GPs had opportunistic peer support on a day to day basis, to discuss clinical matters, audit results and clinical guidelines but these were not formally documented or structured.

The lead GP and practice manager did not have regular meetings to review significant events and complaints to determine areas to focus on and to drive service improvement within the practice. Issues were discussed and resolved as they arose. Significant incidents were not shared with all staff, for example, we were told that clinical incidents were not discussed with non-clinical staff. Complaints were reviewed with all staff annually.

Although the premises were shared with another practice, there was limited evidence that the practices provided peer support and shared learning. The lead GP said that matters were discussed as needed with the other GP practice and sought peer support from GPs in practices within the network and had good working relationships with these. There were no formal meetings set up with other practices or evidence of shared learning with the locality.

We identified from reviewing staff training records, that although the practice had identified training needs, it was not always proactive in ensuring these training needs were met in a timely way. For example, some staff were out of date with mandatory training such as basic life support and some staff had not received safeguarding adults training or fire training. However we saw from a complaint received and detailed investigation, an action plan had resulted that required training for administrative staff in conflict

Are services well-led?

Requires improvement

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

resolution and communication. The practice showed us the information provided to administrative staff around conflict resolution information and the link to access to online training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: We found that the registered person did not do all that was reasonably practicable to mitigate risks to health and safety of service users, did not ensure that the persons providing care or treatment had the necessary qualifications competence, skills and experience, did not ensure the premises used by the service provider were safe for their intended purpose, had not ensured proper and safe management of medicines, and had not fully assessed the risk and assured adequate control of the spread of infections. This was in breach of regulation 12(2)(b)(c)(d)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: We found that the registered person did not have adequate systems and processes to enable them to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk. This was in breach of regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.