Dr Ngozi Uduku (Woodlands Health Centre)

Quality Report

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

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Overall summary

Dr Ngozi Uduku, also known as the Woodlands Health Centre, is a single site practice that caters for over 7000 patients living in the Hither Green and Lewisham areas in South London. The practice serves a diverse and multicultural population with the highest proportion of its patients falling within the working age category.

We carried out the inspection on 8 July 2014. As part of the inspection we looked at all the regulated activities provided by the service which are diagnostic and screening, maternity and midwifery, surgical procedures, and treatment of disease, disorder or injury.

We spoke to staff, patients and their relatives. We also spoke to other professionals involved in delivering integrated care such as district nurses, palliative care, pharmacists, health visitors and psychologists. We collected patient views through comments cards that were left at the practice two weeks prior to the inspection.

The practice had procedures to safeguard patients from harm. There were systems in place to prevent the spread of infection, manage medicines, deal with emergencies and maintain the premises and equipment.

There were effective systems in place to ensure that staff followed national guidance and audited clinical practice.

. There was a training and appraisal schedule for both clinical and non-clinical staff. The practice worked with other health care professionals to provide effective care for patients.

The practice was caring and patients were treated with dignity and respect. End of life care and bereavement support was provided or patients were signposted to local agencies where needed. Patients described clinical staff as attentive and reception staff as polite. We observed reception and clinical staff speaking to patients in a polite manner.

Staff told us that the managers and the lead GP were approachable and that there was an open and transparent culture. Staff were supported to develop and progress within their roles, including access to relevant courses or career pathways. The leadership ensured that patients and the Patient Participation Group were involved in the running of the practice.

The practice was responsive to the needs of the population it served. The premises was able to accommodate wheelchair user and provider interpreter services for patients for whom English was not their first language. Extended opening hours were provided including a Saturday morning clinic every last Saturday of the month, for the working population.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Safeguarding policies were in place in order to protect patients from harm. Medicines were checked and stored appropriately. Infection control procedures were followed and regular infection control audits were completed and actioned in order to minimise the risk of infection to patients. There were appropriate procedures in place to ensure that there were always enough staff with the appropriate skills to run the daily clinics. Adequate cover was provided for sickness and other absences.

Staff had opportunities to learn from incidents or significant events during regular meetings and by emails, in order to prevent recurrence of the same incidents. The practice had regular meetings with the health visitors team and had multiagency meetings to discuss child protection issues.

There were procedures in place to deal with medical emergencies including regular checks on the medication oxygen and equipment. Staff had up to date Cardio Pulmonary Resuscitation (CPR) training that was updated annually and knew where to locate the emergency medication, oxygen and defibrillator in the event of an emergency.

Are services effective?

There were effective systems in place to ensure that staff followed appropriate guidance when delivering care. Staff were updated regularly at weekly clinical meetings to ensure that they used evidence based practice and national guidance such as The National Institute for Health and Care Excellence (NICE).

There was a training and appraisal schedule for both clinical and non-clinical staff, although the administrative staff schedule could be improved.

Patients with long term conditions were monitored by staff and referred appropriately to other professionals such as dieticians, physiotherapists, psychologists and district nurses. There were systems in place to ensure that repeat prescriptions were managed appropriately.

Staff were supported to keep up to date with professional development and professional registration.

There were several health promotions initiatives including, immunisation, diabetes care and erectile dysfunction.

Summary of findings

Are services caring?

The practice provided a caring service. Patients were treated with dignity and respect. Staff were described by patients as caring and we observed reception and clinical staff speaking to patients in a pleasant manner. Staff spoke discreetly to prevent other patients from overhearing. They told us they used a separate room to talk to patients who may be distressed or need time to digest bad news, such as a newly diagnosed life threatening illness.

The practice made provision for end of life care and bereavement support where needed or signposted patients and their carers to local support groups.

Patients were involved in planning care and carers were involved with the patient's consent. Staff were aware of capacity to consent issues and told us how they involved family and carers in planning care for children, end of life and where patient's capacity was diminished due to their health condition. Most patients we spoke with told they felt involved in their care..

Are services responsive to people's needs?

The practice was responsive to the needs of the population it served. There was provision for speakers of other languages where required via an interpreter or telephone interpreter services. Woodlands Health Centre opened early and late on a Tuesday and also provided a Saturday morning clinic every last Friday of the month in order to accommodate the majority of its patients who were in the working age category.

Complaints were responded to according to the practices policy in a timely manner and sought to address and resolve issues raised. Staff were aware of the complaints policy. Complaints we looked at concerned issues such as staff attitudes and waiting times, once patients had arrived for their appointment. This was addressed by encouraging staff at the reception to inform patients about current waiting times when they presented for their appointment.

Are services well-led?

The practice was well led. Both clinical and non clinical staff said that the managers were approachable and that there was an open and transparent culture. Staff were supported to develop and progress within their roles. Patients and the Patient Participation Group (PPG) were involved, where possible, in making decisions about care and their views and feedback were sought in order to improve patient experience.

There were systems in place to ensure that staff focussed on the quality of care delivered and reflected on practice in order to

Summary of findings

improve patient care. We saw evidence that regular team meetings and clinical audits took place. Staff appraisals also took place annually and gave staff the opportunity to seek further training and plan for any areas they needed to develop.

Summary of findings

The six population groups and what we found

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

Older people

The practice provided a safe and effective service to approximately 174 patients aged over 75. It had various health promotion clinics and an on- call service which provided home visits. The practice worked closely with two care homes in the locality responding promptly when called out to review patients living at the homes. All patients over 75 had a named doctor on the computer system that was responsible for ensuring that the physical and psychological needs of the patient were recognised and responded to in a timely manner by all clinicians involved within and outside the practice.

Regular patient care reviews took place, involving patients and carers. These included medicine reviews and annual health checks. The practice had links with district nurses and other healthcare professionals to ensure patients and carers receive appropriate coordinated, multi-disciplinary input in their home or in a care home setting. This joint approach was also consolidated at integrated meetings.

We found that staff were knowledgeable and able to demonstrate how they responded to the needs of patients with dementia and other long term conditions such as hypertension, heart disease and Chronic Obstructive Pulmonary Disease (COPD).

People with long-term conditions

The practice provided a safe, effective, responsive and caring service to patients with long term conditions. Woodlands Health Centre currently had 87 patients with Chronic Obstructive Pulmonary Disease (COPD), 298 patients with diabetes, 41 patients with heart failure and 88 cancer patients. It also had between 25-140 patients with epilepsy, stroke, heart failure and rheumatoid arthritis.

Long term conditions were catered for effectively by ensuring that annual health checks were offered to patients. These included medicine and spirometry reviews for patients with COPD. A smoking cessation service was offered to all patients. There was joint working with specialists such as community respiratory nurses, the local hospital respiratory team, diabetes nurses and dieticians.

Mothers, babies, children and young people

The practice provided safe and effective care to approximately 600 mothers, 802 babies, 869 children and 334 young people. The

practice conducted weekly antenatal and post natal, family planning and child health clinics. The practice offered shared care, midwife-led care and total maternity care. They supported midwives following home deliveries.

The working-age population and those recently retired

The practice provided a safe, effective a service for working age people and those recently retired. The practice had flexible opening hours to enable the 5391 working population to access services and offered commuter clinics every Tuesday from 07:00 to 08:00 and from 18:00 to 19:00. Every last Saturday of the month morning appointments were also available from 07:00 to 10:00. The practice offered health checks for over 40's.

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

The practice provided safe care to vulnerable groups by providing care that did not discriminate. They delivered individualised care where possible or signposted people to other local agencies or practices that could offer the required service. There were effective systems in place to ensure vulnerable people such as the 23 patients registered with a learning disability, were reviewed and supported appropriately.

People experiencing poor mental health

The practice provided a safe, caring and effective service to patients experiencing poor mental health. Woodlands Health Centre looked after 128 patients with mental health conditions in the community and another 27 patients within a psychiatric unit. Approximately 1000 patients registered at the practice had experienced either mild or severe depression. A clinical psychologist was attached to the practice and attended quarterly multi-disciplinary meetings. All patients were reviewed yearly and others more frequently depending on their risk assessments. The practice liaised closely with the consultant psychiatrist and their teams at the community mental health unit.

Summary of findings

What people who use the service say

Most patients thought the practice was providing a safe, effective, caring, responsive and well led service. The Department of Health GP Patient Survey completed between 01/01/2013 and 30/09/2013 showed that patients were not satisfied with their ability to make an appointment. 66.1% of patients rated their experience at Woodlands Medical Centre as good or very good which was lower than other practices in the area.

The survey completed by the practice in 2013, by 87 about of a possible sample of 300, showed that all issues raised which were Drop- in sessions, waiting times, telephone bookings and prescriptions had an on-going action plan in place to address and resolve them. Patients who completed feedback on the NHS choices website between January and July 2014 stated that waiting times could be reduced and reception staff attitude could be improved when trying to access emergency or same day appointment. We spoke to one of the managers about this and they told us that several changes and training were in the process of being implemented in order to improve the patient experience. We also saw administrative staff meeting minutes from meetings held in June 2014 which verified this had been discussed.

We collected 22 comment cards where patients told us that they were very happy with the care and treatment they received from doctors and nurses. We spoke to 10 patients on the day of our visit. Most said they were very happy with the care and treatment. Others said they would have preferred to wait for a shorter time when they arrived for an appointment. One patient said they sometimes had to wait for over 45 minutes whilst another three out of the 22 comment cards received noted that they were never seen on time but did not specify the exact waiting times. They all said they had been treated with respect and that they had confidence and trust in the doctors and nurses who attended to them. We also spoke two members of the Patient Participation Group (PPG) who told us that they were happy with the way in which the practice engaged with them but thought the Electronic Prescription Service (EPS) could be improved.

Areas for improvement

Action the service SHOULD take to improve

The practice needed to ensure that all staff knew that they needed to notify safeguarding cases to the Care Quality Commission (CQC).

The practice could purchase an Electrocardiogram (ECG) machine instead of referring patients to another practice, in order to speed up the diagnosis of cardiac conditions for patients presenting with palpitations.

The practice could purchase a defibrillator in order to better equip staff when dealing with medical emergencies.

Dr Ngozi Uduku (Woodlands Health Centre)

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector, CQC inspector, a GP specialist advisor, a practice manager specialist advisor and an expert by experience (a person who has had experience of using health care services first hand or a carer of a regular user of healthcare services). The specialist advisors and the expert by experience were granted the same authority to enter the Woodlands Medical Centre as the CQC inspectors.

Background to Dr Ngozi Uduku (Woodlands Health Centre)

Woodlands Health Centre is GP practice that provides a range of primary medical services for over 7000 patients in Lewisham. NHS Lewisham Clinical Commissioning Group (CCG) is made up of 44 local GP surgeries. In Lewisham, 46.5% of the population belong to non-white minorities which is higher than the England average of 12.3%.Deprivation levels, child poverty, childhood obesity, drug misuse, new cases of tuberculosis, acute sexually transmitted infections are significantly worse than the England average.

The practice has one lead GP, five salaried GPs, two nurses, a healthcare assistant; six reception staff, a practice manager and a business services manager. A named district nurse, health visitor and a team of community midwives is attached to the practice.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations, NHS England and Clinical Commissioning Group (CCG) to share what they knew about the service. We reviewed the General Practice Outcome Standards (GPOS) data which cover a range of services provided by general practice and represent the level of care everyone should expect to receive from their GP surgery. We also reviewed General Practice High Level Indicators (GPHLI) which is a tool developed to provide comparative data used by GPs as a reflective tool for quality improvement purposes. We also examined views from patients from Healthwatch and NHS Choices websites.

We carried out an announced visit 8 July 2014. During our visit we spoke with a range of staff including nurses, administrative staff, GPs and the practice manager. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We spoke to ten patients and two members of the PPG. We reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service and looked at practices polices and maintenance records.

Are services safe?

Our findings

Safe patient care

Staff described how they reported and recorded incidents such as infection outbreaks and reporting errors. They told us that they learnt about the latest incidents at the weekly clinical meetings. Staff said they felt management encouraged them to acknowledge any mistakes and learn from them. Information was also shared by the clinical lead when alerts were received from the national patient safety agency

We were shown on the computer records system, how administrative staff ran checks to ensure that people requiring cervical smears were sent reminder letters promptly. Similar systems were used for annual health checks for people with diabetes or hypertension where all applicable tests to an individual were flagged up on the screen each time the patient came for a consultation. Referrals and incoming post were also managed appropriately by administrative staff on a daily basis, in order to minimise delays in treatment.

Learning from incidents

Incidents were discussed at weekly practice meetings. Four of the seven clinical staff we spoke to provided examples of lessons learnt following previous incidents. This included one that had occurred in March 2014 where a medicine had not been discontinued on time due to a back log in processing letters. Systems of opening and actioning letters had changed with clearer responsibilities for administrative staff leading to a reduced backlog as letters were processed daily and scanned onto the electronic patient records.

We reviewed the significant event analysis records and found that measures had been put in place to avoid recurrence of these incidents. These included an audit that had commenced to ensure that patient's blood tests were monitored before issuing repeat prescriptions for medicines such Angiotensin-C converting Enzyme (ACE) inhibitors (medicines used to treat high blood pressure and heart failure).

Safeguarding

Clinical staff had completed safeguarding training for both adults and children at the appropriate level Doctors and nurses had attended Level 3 child protection training. For administrative staff, staff needing updates had already been identified and training had been booked. Staff were aware of who the safeguarding lead was at the practice. They told us that they would report any concerns such as neglect or domestic violence.

A health visitor attended the practice's integrated care meetings and was aware of the children and families where the practice had concerns. The practice's computer system also flagged up all children and families where child protection concerns had been identified. Safeguarding child and adults policies were in place with a named lead GP. However, staff were not aware that safeguarding cases needed to be reported to the Care Quality Commission. (CQC).

Monitoring safety and responding to risk

Risk assessments on the safety of the premises and equipment were completed. Fire doors were kept shut and fire exits were clearly labelled and free from obstruction. We saw records to evidence that health and safety checks, fire alarm checks, building insurance and electrical testing were in date. There was a system in place to ensure these never lapsed.

There were appropriate procedures in place to ensure that there were always enough staff with the appropriate skills to run the daily clinics. Adequate cover was provided for sickness and other absences such as annual leave. Staff told us that most absences were covered by regular staff and that agency staffing was rarely used.

Medicines management

We looked at the storage of medication held by the practice and saw that all stock was secure. The practice did not store controlled drugs. Repeat prescriptions were managed within 48 hours of arrival and an electronic prescription service was available. There was an emergency trolley, oxygen and records listing the contents and that all were checked weekly so that they were available and fit for use.

The lead GP was on the local Clinical Commissioning Group (CCG) prescribing board and therefore was always aware of what other practices were doing and how they compared with similar practices in the area. The practice had a young population and was aware that antibiotic prescribing and Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) prescribing was higher than in other practices in London

due to the age of the patients. However, they ensured consistency in prescribing and monitoring. For example, all GPs used Ibuprofen as the first line of treatment and naproxen as second line of treatment for arthritis.

The practice kept vaccines which were stored at the required temperature to ensure they were safe to use. Fridge temperatures were recorded to provide evidence that the cold chain was maintained. Osteoporosis audits were also completed yearly and improvement made to prescribing where appropriate.

Cleanliness and infection control

Infection control procedures were followed and regular infection control audits were completed and actioned in order to minimise the risk of infection to patients. The practice had an identified infection prevention and control (IPC) lead and staff had attended training. There were cleaning schedules in place and staff told us they had access to protective equipment. Clinical staff told us they adhered to single use equipment and told us how they cleaned examination couches and other equipment before use. Hand washing posters were displayed next to the hand washing area in all consulting rooms.

Sharps bins were correctly assembled and not overfilled. Staff were aware of the location of spillage kits and were aware of the procedure to follow if a needle stick injury occurred.

Staffing and recruitment

There were appropriate recruitment and selection procedures in place for staff including an induction program and issuing of a comprehensive staff handbook. Records showed that two references, curriculum vitae, qualifications and professional registration details were kept on file for all staff. We were told and shown files that contained disclosure and barring checks for staff were appropriate.

Dealing with Emergencies

There were procedures in place to deal with medical emergencies including regular checks on the medication oxygen and equipment. Staff had up to date Cardio Pulmonary Resuscitation (CPR) training which was updated annually and knew where to locate the emergency medication and oxygen in an emergency. Staff told us that fire testing occurred weekly and were aware of the evacuation procedures in the event of a fire.

Equipment

There were procedures in place to ensure that all equipment was calibrated yearly. Staff were aware of the different reporting systems in place for faulty equipment. There were protocols for cleaning all clinical equipment and staff were aware of single use items.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

Weekly clinical meetings and three monthly integrated care meetings took place to ensure that all staff delivered care in line with best practice recommendations for patients. There were clear protocols in place to ensure that patients on Warfarin or methotrexate had their blood tests and medicines reviewed according to national guidelines. Staff gave examples of how they used National Institute for Health and Care Excellence (NICE) guidelines in their daily assessments for patients with diabetes.

Clinical and non-clinical staff demonstrated knowledge of the Mental Capacity Act (MCA) 2005 and how the practice used this including informed and implied consent for treatments such as immunisations, health checks and blood tests. Clinical staff were able to give instances of where they had assessed capacity or had referred patients to specialists for further assessments, to determine capacity or diagnose conditions such as dementia. Staff told us that they had attended mental capacity training and we saw some certificates that verified this.

Management, monitoring and improving outcomes for people

We saw an example of a recently commenced audit to ensure that regular blood tests were being carried out on patients who were prescribed ace inhibitors (medicine used to treat patients with either heart conditions or high blood pressure.) This was as a result of a recent incident relating to repeat prescription being issued without reviewing blood
results.

Management of Disease-Modifying Antirheumatic Drugs (DMARDS) (drugs used to treat a condition called rheumatoid arthritis which is inflammation of the joints) was done in conjunction with the local Out-Patient Department (OPD). The practice had access to the OPD computer system where they could check blood results and record them in patient records before issuing repeat prescriptions.

Audits, such as blood pressure home monitoring, were completed to ensure at risk patients received appropriate treatment. We saw an Ear Nose and Throat (ENT) referral audit where the practice had appropriately referred 95% of the patients referred for specialist ENT input.

Staffing

The practice had a principal GP, five salaried GPs, two nurses, one health care assistant and six reception/ administrative staff. There was also a business services manager and a practice manager. Skill mix was based on analyses of patterns of demand. Most administrative staff had been at the practice for a long time. However, the salaried GPs had joined in 2014. We reviewed training records and found that mandatory training which included basic life support, health and safety and infection control was up to date. Staff said they were supported to attend other courses relevant to their job.

All staff received annual appraisals. There was a training and appraisal schedule for both clinical and non-clinical staff, although the administrative staff schedule could be improved. Clinical staff told us that they were up to date with their Continuing Professional Development (CPD) and we saw certificates that verified this. Nurses' registration with the Nursing and Midwifery Council (NMC) was valid and all four GPs we spoke to were aware of when their revalidation was due and had valid General Medical Council (GMC) registration.

Staff told us that they had access to equipment such as spirometry, blood pressure monitoring and blood glucose monitoring equipment and that all equipment was serviced annually to enable safe delivery of care. There was no ECG machine at the practice, however staff told us they referred patients with cardiac concerns to clinics where they could have an ECG the same day. The practice could purchase an ECG machine instead of referring patients to another practice in order to speed up diagnosis of cardiac conditions for patients presenting with potential cardiac problems

Working with other services

The practice had working relationships with midwives, district nurses and two residential care homes. The practice also liaised frequently with staff and patients at a home that provided care for patients with mental health conditions. There were quarterly monthly multidisciplinary meetings with the psychogeriatrician, district nurses and health visitors to discuss patients with palliative care needs and those in a care home setting with long term health conditions.

Are services effective?

(for example, treatment is effective)

The practice had established joint working arrangements between the health visitors and practice nurses, who worked together to do the baby checks and immunisations at the same time in a joint clinic, to prevent mothers from needing to book two appointments.

Discharge letters from patient's visits to hospital and out of hours services were scanned into the practice's computer systems. The relevant GP was then sent a task using the electronic records system, where there would then review the information.

Health, promotion and prevention

The practice ran several health promotion clinics for long term conditions such as diabetes, asthma and epilepsy. Nurses provided healthy eating lifestyle advice and erectile dysfunction advice, as well as smoking cessation advice during routine consultations.

Weekly baby clinics were held where developmental checks and immunisations were offered to all mothers of children under the age of five.

The practice ran a travel clinic and we saw the comprehensive medical questionnaire that patients were given before they gave their consent for vaccinations. The practice nurses had access to a specialist travel advice service and they administered vaccines. All batch numbers of vaccines and expiry dates were recorded on the patient's individual electronic record and also their travel log.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients were treated with dignity and respect. Staff were described by patients as caring. However, a few comments on the NHS choices website suggested that some reception staff were rude or unhelpful over the phone and in person. We spoke to the business services manager about this and they showed us evidence that communication and performance issues were discussed with the relevant staff.

We observed reception and clinical staff speaking to patients in a pleasant manner. Reception staff spoke in soft voice tone over the telephone and in person to prevent other patients from overhearing. Staff showed us a separate room that could be used to talk to patients in private when required.

Patients told us that the doctors and nurses were respectful and polite at all times. Reception staff told us that they had attended training on dealing with and resolving conflict or managing difficult situations. Staff were aware of the chaperone policy which was displayed in the consulting rooms. Most chaperoning was conducted by administrative staff who had been trained. Patients and staff told us patients could choose to be seen by a doctor of the same gender if they wanted. The practice had one male and five female doctors.

End of life care and bereavement support was provided where required or patients were signposted to relevant organisations that offered palliative care support, carer support and bereavement support. Staff told us that patients who presented with pain were prioritised.

Involvement in decisions and consent

A palliative care register was maintained and regularly updated. Patients nearing the end of life were offered an opportunity to discuss their needs and preferences. Patients, their families and carers on the register were assessed and offered support to help them live as actively as possible and with dignity.

Clinical and most non clinical staff were able to demonstrate how they would provide information to patients who may be unable to consent to care including children, those living with dementia and people with learning disabilities. They told us and showed us how the electronic system would show that parental or guardian consent for immunisations was sought. and that advocates were sought for adults who were unable to consent for themselves. It may be useful for the practice to note that some administrative staff were unsure about how to handle young people who presented at the surgery for an appointment without an adult. We also saw evidence of how next of kin were involved in planning the care of patients with a mental health condition or patients who had a learning difficulty.

Patients told us that they felt included in their care and treatment. Fifteen out of the 22 comment cards we collected at the practice told us that patient choice was promoted and that they had been involved in planning their care such as medication reviews and referrals to other healthcare professionals. Most patients said they chose whether they wanted to see the same doctor for continuity and that they were always involved in all aspects of their care including medication reviews or with other treatment options such as surgery. Annual patient surveys were completed with the assistance of the Patient Participation Group (PPG). We found that most of the 87 patients who participated in the survey said they were involved in their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We reviewed the practice 2013 patient survey, completed, by 87 out of a possible sample of 300 patients. Issues raised included drop- in sessions, waiting times, telephone bookings and prescriptions and the practice had an on-going action plan in place to address and resolve the issues raised. Appointments systems had also been changed to a daily drop- in morning session with more GPs in order to improve access and reduce appointment cancellations.

The practice planned services for different groups appropriately. It provided home visits for those who could not come out to the practice and also ensured that these patients were included in the regular patient surveys. Patients over 75s had a named GP and were offered annual health checks. Patients with long term conditions such as heart disease, COPD, rheumatoid arthritis and diabetes were offered annual health checks. Regular clinics were held to support them to manage their long term conditions.

There was a practice policy on inequality which staff were aware of and referred to during interviews. The policy included issues such as age discrimination. Staff gave examples of how they tailored care to meet the individual. Examples included registering the homeless and taking extra time to be able to communicate effectively with a patient with learning disability or dementia. They told us that they would take them to a separate room if required. The practice's computer system also alerted staff whether patients had a learning disability or a condition that meant they may require more consultation time.

Patients could choose which doctor they saw and were advised at the time of booking when their chosen GP was working. There was a duty doctor daily to deal with emergencies and home visits. There was a patient participation group (PPG) which met every three months and felt supported by the practice. The PPG annual report from April 2013 to March 2014 demonstrated involvement of the PPG in deciding how they wanted to be cared for including appointment times

Patients were referred to other nearby practices for fitting of intra uterine devices (IUDs) (Coils used as a method of contraception) and specialist sexual health clinics. Patients could be referred to other health care professionals after their appointment with a nurses or doctor. Staff gave examples of how they had signposted people to Improved Access to Psychological Therapies (IAPT) services, social services and other local agencies such as MIND (an agency that provides help and support for people with different mental health conditions). A counsellor providing IAPT services was available at the practice every Friday.

Access to the service

The practice was accessible for wheelchair users via a ramp and a push button door. Staff said they assisted wheelchair users to get through the doors leading to the consulting rooms. The practice opened early on a Tuesday from 07:00 to 08:00am and later from 18:00 to 19:00 in order to accommodate patients who worked. The practice also opened on the last Saturday of the month from 07:00 to10:00am. Appointments could be made in person or over the phone. There was provision for speakers of other languages where required via an interpreter or telephone interpreter services.

Drop- in sessions were available every morning between 10:00am and 12:00pm. Out of hours services were provided by South East London Doctors Cooperative Limited (SELDOC) and this information was highlighted on the website and on patient leaflets. Calls to the surgery automatically diverted to the out of hours service once the surgery was closed.

Patients had mixed views on the appointments system as some thought the practice could be more responsive by reducing waiting times and improving staff attitudes during telephone bookings. We reviewed action plans that were in progress in order to reduce waiting times and address the frustrations expressed by patients during drop in sessions. These included the recruitment of four new doctors who worked part time in order to reduce the pressure for appointments.

Concerns and complaints

The main concerns identified prior to the inspection from the national GP Survey, NHS Choices website were negative feedback about communication at reception and recent GP turnover. Positive aspects were that the practice was very good at providing continuity of care as patients usually were able to see the GP of their choice.

Are services responsive to people's needs?

(for example, to feedback?)

Staff were aware of the complaints policy and procedure and told us that they would try and resolve issues before escalating to the practice manager. We were told that complaints were responded to promptly. We reviewed complaints made in the last year and found that these were logged, investigated and resolved in accordance with the practice policy. The main concerns were about the length of waiting times once patients arrived for their appointment and patients having to come back after booking morning drop-in session appointments. One complaint had been about a patient feeling that a clinician had been rude during consultation and another about telephone access being a problem in the morning. It was evident that the practice had reviewed this and was reminding patients of various times that the telephone lines were less busy.

Patients we spoke to on the day were aware of the procedure to follow if they wanted to make a complaint. The comment cards we reviewed showed that most people were happy and had not made a formal complaint. A few who indicated they had made a complaint were satisfied with the way their complaint was handled.

Are services well-led?

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

Our findings

Leadership and culture

Staff were aware of the practice's vision which could be found on the website, on patient leaflets and on staff information packs issued when staff were recruited. The vision was to provide the best healthcare to patients in the Hither Green area. All staff were clear on the management structure and the responsibilities of each of the managers and GPs. Staff said they worked together as a team and shared examples of how they could seek advice from another doctor or from one of the nurses.

There was a new business services manager who started in April 2014. They had made changes in order to make systems more effective and move from a paper to computer- based way of recording and tracking important messages and significant events. Human Resource practices such as performance management and disciplinary procedures were clear and implemented where necessary. Team working was promoted and the staff rota had clearly defined duties described in order to ensure that administrative and clinical staff were aware of their duties and responsibilities.

Governance arrangements

The practice had comprehensive policies and procedures in place to support the safe management of medicines, safeguard vulnerable adults and children and clinical practice. There were clear recruitment strategies and risk management strategies such as a business continuity plan to ensure that patients received safe care. Staff were aware of who the lead for safeguarding and infection control and who was responsible for updating the practice policies.

Systems to monitor and improve quality and improvement

The practice continually audited different areas of clinical practice and medicines. Weekly clinical meetings were used as a platform to discuss patient care issues, including complaints and significant incidents, to ensure that learning from incidents took place. GPs told us about updates on the management of Atrial Fibrillation (AF), which means an irregular heartbeat. Due to the prevalence of AF in Lewisham the practice was encouraging clinical staff to check patients' pulses when they attended and refer if necessary to the local AF clinic. Systems were also in place to monitor and improve outcomes for patients with mental health conditions who also presented with other medical conditions.

Patient experience and involvement

We reviewed the patient survey, completed by the practice in 2013, by 87 out of a possible sample of 300 patients. It showed that all issues raised which were drop- in sessions, waiting times, telephone bookings and prescriptions had an on-going action plan in place to address and resolve issues raised. Appointments systems had also been changed to a daily drop- in morning session with more GPs in order to improve access and reduce appointment cancellations[MM1] .

The practice manager responded to patients who left comments on the NHS choices website in a timely and appropriate manner. There were comments in the last six months relating to attitudes of reception staff and drop- in sessions and they had all been responded to if concerns had been identified or acknowledged if complimentary comments were made.

There was a patient participation group (PPG). We spoke with two members of the PPG who told us about their involvement in patient satisfaction surveys. They met every three months and felt supported by the practice. Their annual report from April 2013 to March 2014 demonstrated involvement of the PPG in deciding how they wanted to be cared for including appointment times.

Staff engagement and involvement

Staff told us that the practice was very supportive and felt they were listened to by senior management. They said the practice welcomed suggestions and that all staff groups were given the opportunity to express their views at clinical meetings or directly with the practice manager. Weekly clinical and fortnightly administrative staff meetings were in place in order to review performance and gather staff feedback. The practice was going through changes due to the appointment of a new business services manager and four new GPs. Although some staff did not like some of the changes, reasons and timescales for the changes were clear and staff acknowledged that the managers recognised hard work.

Staff were aware of the whistleblowing policy and told us that they felt their manager was approachable. They told us they could raise concerns without any fear of reprisal.

Are services well-led?

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

Staff said they were able to have study days each year and were happy with their contractual working arrangements. We saw an updated staff handbook which had been given out to all staff to ensure they were up to date with all the policies and changes.

Learning and improvement

GP's told us that they received staff feedback regularly and thought the leadership was very democratic. The practice had recently recruited four salaried GPs and all of them had completed an induction program. They felt supported by the lead GP and by attending the weekly clinical meetings. Significant incidents were now being recorded on the computer system instead of the paper-based version making them accessible on several computers and easier to locate for future reference.

There were plans in place for one of the salaried GPs to become a partner within the next six months. Salaried GPs told us that the leadership was very supportive and encouraged them to offer as many services as possible. For example, one recently appointed salaried GP had an interest in fitting Intra Uterine Devices (IUDs) whilst another had an interest in joint injections and some minor surgery. There were discussions in place to facilitate both GPs so that they could offer these services to patients when required.

Identification and management of risk

Risks were monitored using the QOF (Quality and Outcomes Framework) which measured how the practice was achieving in terms of patient experience and clinical organisation. There were procedures in place to ensue staff were aware of how to report and deal with incidents. Risk assessments were in place for the premises and for patients. There were systems in place to monitor patients with long term conditions and those on medications with potentially toxic side effects such as methotrexate and warfarin.

Older people

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

Our findings

The practice provided a safe and effective service to approximately 174 patients aged over 75. It had various health promotion clinics and an on- call service which provided home visits. The practice worked closely with two care homes in the locality responding promptly when called out to review patients living at the homes. All patients over 75 had a named doctor on the computer system that was responsible for ensuring that the physical and psychological needs of the patient were recognised and responded to in a timely manner by all clinicians involved within and outside the practice.

Regular patient care reviews took place, involving patients and carers. These included medicine reviews and annual health checks. The practice had links with district nurses and other healthcare professionals to ensure patients and carers receive appropriate coordinated, multi-disciplinary input in their home or in a care home setting. This joint approach was also consolidated at integrated meetings.

We found that staff were knowledgeable and able to demonstrate how they responded to the needs of patients with dementia and other long term conditions such as hypertension, heart disease and Chronic Obstructive Pulmonary Disease (COPD).

All patients aged 75 and over had a named GP and over were offered annual health checks which included medication and chronic disease reviews, height and weight check as well as various blood tests. Next of kin and care status updates were also verified during these checks. Regular patient care reviews took place, involving patients and carers. All older patients could see a doctor on the same day or the day of their choice. This allowed problems to be dealt with promptly. Patients were signposted to other support agencies such as Age Concern which was listed in the practice leaflet under a useful numbers list.

Care was tailored to individual needs and circumstances, including expectations, values and choices. Staff told us how they were careful not to label patients and looked at the individual's needs. Patients with dementia were identified and assessed by clinicians opportunistically. We found that staff were knowledgeable, and able to demonstrate how they responded to the needs of patients with dementia and other long term conditions such as hypertension, heart diseases and COPD. Staff said they initially referred to the memory clinic service at the local hospital. Once a diagnosis was established, the level of need was assessed and regularly reviewed with the help of their next of kin. Patients were signposted to other services such as social services and district nurses.

There were effective systems in place to ensure that patients were given care that met their individual needs. Care packages were reviewed regularly and at least 6 monthly for those requiring support at home. The practice offered weekly and “as required” services to two residential care homes, where consistent doctors reviewed patients. There was also a district nurse and tissue viability nurse attached to the practice. The practice also worked with the community mental health team for the elderly. All relevant health care professionals were invited to the multidisciplinary meetings or to drop in unannounced if there was a need to discuss a patient and their care urgently.

Palliative care arrangements were in place. End of life care arrangements were made with the full knowledge and involvement of the patient if they had capacity or their next of kin if they did not have capacity. The local palliative care team were informed and we were told that Do Not Attempt Resuscitation (DNAR) forms were signed and out of hours services notified. These patients were regularly discussed at the multi-disciplinary meetings and regular reviews of symptom relief measures with all those concerned were completed.

People with long term conditions

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

Our findings

The practice provided a safe, effective, responsive and caring service to patients with long term conditions. Woodlands Health Centre currently had 87 patients with Chronic Obstructive Pulmonary Disease (COPD), 298 patients with diabetes, 41 patients with heart failure and 88 cancer patients. It also had between 25-140 patients with epilepsy, stroke, heart failure and rheumatoid arthritis. Long term conditions were catered for effectively by ensuring that annual health checks were offered to patients. These included medicine and spirometry reviews for patients with COPD.

There was joint working with specialists such as community respiratory nurses, the local hospital respiratory team, diabetes nurses and dieticians.

The practice provided a safe service for people with a long term conditions such as diabetes, rheumatoid arthritis, heart failure and epilepsy. We saw that there was a system in place to ensure that annual reviews for patients with Chronic Obstructive Pulmonary Disease (COPD) including medicine reviews and spirometry reviews took place. The practice worked closely with the community respiratory nurses and the local hospital respiratory team.

The Practice had a register for stroke patients, patients with epilepsy, cancer patients and diabetic patients. Patients on any of the registers were offered an annual review. This included medication reviews, comorbidity reviews, and routine blood tests. They were also assessed for any personal and social needs such as financial problems and carers- related issues. For patients with diabetes, reviews included diabetic's life style education, associated health checks such as feet, eyes and renal function tests. The practice worked closely with the local heart failure nurses who saw the patients at their local clinics in order to monitor medication and renal function and also visited patient in their homes.

There were effective systems in place to ensure that people with long term conditions were treated and referred appropriately for treatment. Staff followed relevant clinical guidelines to manage a range of long term conditions. There were various clinics for chronic disease management. Rheumatoid arthritis patients were reviewed yearly and often monthly if they were taking medicines such as methotrexate. A medication review took place based on the results of routine blood tests in order to avoid potential medicine side effects. Social and family aspects of the care were reviewed such as mobility issues, carer issues, financial and housing problems.

Mothers, babies, children and young people

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

Our findings

The practice provided safe and effective care to approximately 600 mothers, 802 babies, 869 children and 334 young people. The practice conducted weekly antenatal and post natal, family planning and child health clinics. The practice offered shared care, midwife- led care and total maternity care. They supported midwives following home deliveries.

The practice had safe and effective services for mothers babies and young people. There were immunisation clinics for children, postnatal checks for women and developmental checks services available. The antenatal clinics were run by the community midwifery service and also one of the GPs at the practice. The post natal clinics were run by one of the GPs at the practice.

The practice had clear structures in place for the management of mothers, babies and children. The leadership promoted joint working such as the practice nurse and the health visitor running clinics together. A weekly child health clinic was run by health visitors, two practice nurses, and one GP. Mothers were encouraged to bring any problems relating to their child to the team, so they could be addressed during the baby checks and immunisations. Safeguarding issues are discussed at this clinic and more formally at monthly meetings when the health visitors attend the clinical meetings.

Staff were aware of issues relating to consent to care and treatment for children. Staff showed us how they recorded parental consent after giving immunisations.

There were systems in place to remind postnatal mothers of their six week check as well as reminders for their children's developmental checks and immunisations. Staff told us and we reviewed minutes that showed that information about management of young people was shared, on issues such as sexually transmitted diseases and healthy lifestyle advice

Working age people (and those recently retired)

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

Our findings

The practice provided a safe, effective a service for working age people and those recently retired. The practice had flexible opening hours to enable the 5391 working population to access services and offered commuter clinics every Tuesday from 07:00 to 08:00 and from 18:00 to 19:00. Every last Saturday of the month morning appointments were also available from 07:00 to 10:00. The practice offered health checks for over 40's.

There were effective systems in place to ensure that people's needs were met. There were a range of clinics available including cervical smears, sexual health advice, contraceptive services and breast awareness advice. Vascular disease health checks were offered to all those aged between 40 -74 years. Medication reviews and anti-coagulation optimisation and review were undertaken. All clinicians checked the pulse of all the patients aged 40 and over and all those on ischemic heart disease and cerebrovascular accident (CVA) registers in order to increase detection of atrial fibrillation (AF). These services helped to detect and prevent diseases at an early stage.

The surgery was responsive to the needs of working people and the recently retired by having extended opening hours. The surgery opened from 07:00 to 10:00 every last Saturday of the month and also between 07:00 and 08:00 and between 18:00 and 19:00 every Tuesday.

Most of the patients we spoke to and seven out of the 22 comment cards we reviewed commented positively on the accessible hours provided. Three said they would like it if the surgery opened early most days. Comments also showed that people were happy with the choose and book system which enabled them to book appointments at a hospital of their choice. One person said they had been able to access a support service during their lunch break after being signposted by the practice nurse.

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

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

Our findings

The practice provided safe care to vulnerable groups by providing care that did not discriminate. They delivered individualised care where possible or signposted people to other local agencies or practices that could offer the required service. There were effective systems in place to ensure vulnerable people such as the 23 patients registered with a learning disability, were reviewed and supported appropriately.

The practice had a system to assess and plan care and treatment for vulnerable people, such as those with a learning disability. There were 23 patients on the learning disability register and annual health checks were offered to all. On the day of our visit most of these patients had attended an annual health check or had an appointment booked to attend.

Staff told us how they supported patients and their carers and treated patients with dignity and respect. There were systems in place to support carers by signposting them to relevant local support groups. Staff were aware of issues relating to capacity to consent, and told us that some of the patients with learning disability visited with a carer depending on the severity of their condition and their capacity to make decisions.

There were no specific services for the homeless or travellers. Other vulnerable groups were identified opportunistically, discussed at weekly clinical meetings and often signposted to local services such as refugee groups, Sexually Transmitted Infections (STI) clinics and social services.

People experiencing poor mental health

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

Our findings

The practice provided a safe, caring and effective service to patients experiencing poor mental health. Woodlands Health Centre looked after 128 patients with mental health conditions in the community and another 27 patients within a psychiatric unit. Approximately 1000 patients registered at the practice had experienced either mild or severe depression. A clinical psychologist was attached to the practice and attended quarterly multi-disciplinary meetings. All patients were reviewed yearly and others more frequently depending on their risk assessments. The practice liaised closely with the consultant psychiatrist and their teams at the community mental health unit.

GPs attended mental health review meetings when possible with the Community Psychiatric Nurses (CPNs) and local psychiatrist. Annual comprehensive reviews including health checks, blood tests and alcohol and smoking reviews were completed. We found that 108 of the 128 patients with a mental health condition had a care plan that had been agreed care plans with the patient and their carer or next of kin. 111 of the 128 patients had blood pressure (BP) checks in 2014 with the remaining 17 patients having letters in progress to invite them for a BP check. On the day of our visit 120 of the 128 patients had alcohol intake recorded and advice given where required. We found that 28 of the 128 patients were female patients and they had all completed their smear tests.

Details of the CPNs and other services involved to the patient's care were regularly updated on the computer system. These patients were reviewed monthly and sometimes more frequently if required.

The practice had a well led service where provision was made to ensure that patients with mental health needs were assessed and referred appropriately to other agencies. At least 20-30% of the patients at the practice presented with depression or illnesses associated with depression throughout the year. Depressed patients were assessed by clinicians and followed up as required. Referral to the counselling services and commencement of anti-depressants were offered if appropriate. Patients were risk assessed and referred for counselling or to the psychiatrists as necessary. The practice also referred to a crisis team where patients presented with severe depression.

There were systems in place to follow up referrals made and to work jointly with specialist mental health teams. GPs told us risk assessments for patients presenting with depression were carried out routinely by all clinical staff and showed us evidence of this on the computer system .A clinical psychologist was attached to the practice. They attended integrated care meetings and completed psychiatric assessments. Experienced counsellors who worked with the clinical psychologist and counselling students also worked at the practice on a sessional basis.