James O'Riordan Medical 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.

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at James O'Riordan Medical Centre on 27 October 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Most risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Most staff had received training appropriate to their roles.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt very supported by management. Staff had received appraisals and attended regular staff meetings.
- Policies and procedures were accessible for staff and were updated to reflect changes in practice systems.
- The practice sought feedback from staff and patients, and they were in the process of developing the Patient Participation Group (PPG).

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

Importantly the provider should:

- Review practice systems for monitoring and recording staff training.
- Proactively make effective use of coding to enhance the ability to monitor patient outcomes.
- Ensure that the Patient Participation Group is formally established.

Summary of findings

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?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events and lessons were learned from these, with action being taken as a result.
- We were told that if there were any unintended or unexpected safety incidents, people would receive reasonable support, truthful information, a verbal and written apology and would be told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were mostly assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data showed patient outcomes were mixed, with some outcomes below, in line with or above average for the locality.
- There was evidence of completed clinical audit cycles to demonstrate that audit was driving improvement in performance to improve patient outcomes.
- Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely.
- Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.
- Staff worked effectively with multidisciplinary teams and held monthly meetings to discuss patients on the palliative register.
- Patients who attended accident and emergency and those deemed most at risk of admission to hospital were closely monitored via weekly meetings.
- Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.
- There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data showed that patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- 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) to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led.

- It had a clear strategic vision. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt very supported by management.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There were systems in place to monitor and improve quality and identify risk.
- The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was in development.
- Staff had received appraisals and attended regular staff meetings.

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

Good

The practice is rated as good for the care of older people.

- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.
- The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia diagnosis and avoiding unplanned admissions to hospital.
- The practice provided health checks and annual reviews for those over 75 and had completed 158 since April 2015.
- It was responsive to the needs of older people, and offered home visits, longer appointments and urgent appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management, specifically patients with respiratory conditions.
- Patients at risk of hospital admission were identified as a priority and were placed on the practice's avoiding unplanned admissions register.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and access to a structured annual review to check that their health and medication needs were being met.
- For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care and there was evidence that these meetings were being used effectively to monitor and improve outcomes for patients nearing the end of life.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of Accident and Emergency (A&E) attendances.

Summary of findings

- Immunisation rates were high for all standard childhood immunisations and in 2014/15 the practice had achieved 99% which was the highest immunisation rate in the Clinical Commissioning Group (CCG) for the five in one vaccine, for those under 12 months.
- 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.
- The practice offered a six week baby clinic and post-natal care for mothers.
- The practice offered health promotion for this population group including chlamydia screening.

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).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Extended hours were offered three days per week and patients were able to access morning or evening appointments.
- The practice was proactive in offering online services for appointments and prescriptions as well as a full range of health promotion and screening that reflects the needs for this age group.
- Appointment reminders and health promotion information was sent by text message and patients could also cancel appointments using this facility.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, housebound patients, vulnerable adults and children, carers and those with a learning disability.

Summary of findings

- It had recently commenced annual health checks for people with a learning disability and 50% of 12 eligible patients had received a follow-up in the six months this service had been provided. It offered longer appointments for people with a learning disability.
- The practice provided a direct contact number for repeat prescriptions for vulnerable patients, including those with cancer, those who were housebound and carers so patients could receive their prescriptions in a timely way.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The lead GP attended monthly Clinical Commissioning Group (CCG) safeguarding meetings.
- The practice held a clinical meeting on a weekly basis to discuss patients who had attended accident and emergency to assist in identifying the most vulnerable patients who had frequent Accident and Emergency (A&E) attendances.
- The practice told vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 88% of people experiencing poor mental health had received an annual physical health check.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- It was proactive in case finding and diagnosing dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- It had a system in place to follow up patients who had attended Accident and Emergency (A&E) where they may have been experiencing poor mental health.
- The practice hosted a psychological therapy service one day a week and were able to refer patients to this service.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing in line with local and national averages. There were 112 responses and a response rate of 36%.

- 95% describe the overall experience as good compared with a Clinical Commissioning Group (CCG) average of 79% and a national average of 85%.
- 91% find it easy to get through to this surgery by phone compared with a CCG average of 60% and a national average of 73%.
- 91% find the receptionists at this surgery helpful compared with a CCG average of 84% and a national average of 87%.
- 69% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 50% and a national average of 60%.
- 93% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 81% and a national average of 85%.
- 95% say the last appointment they got was convenient compared with a CCG average of 88% and a national average of 92%.
- 88% describe their experience of making an appointment as good compared with a CCG average of 66% and a national average of 73%.
- 67% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 55% and a national average of 65%.
- 61% feel they don't normally have to wait too long to be seen compared with a CCG average of 47% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards which were all positive about the standard of care received. Patients reported that they felt they received an excellent service, that staff were always helpful and friendly and patients felt involved in their care and treatment decisions. Patients were also positive about being able to get access to appointments when they needed them.

James O'Riordan Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP specialist advisor, a second CQC inspector, a practice manager specialist advisor and an Expert by Experience.

Background to James O'Riordan Medical Centre

James O'Riordan Medical Centre provides primary medical services in Merton to approximately 6200 patients and is one of 24 practices in Merton Clinical Commissioning Group (CCG). The practice population is in the second least deprived decile in England.

The practice population has a lower than CCG average representation of income deprived children and older people. The practice population of children, older people and those of working age are in line with national averages, however the practice had a higher number of people over 65 at 17% compared with the CCG average of 12%. Of patients registered with the practice, 50% are White and Mixed British.

The practice operates from a purpose-built premises. All patient facilities are on the ground floor and are wheelchair accessible and the practice has access to four doctors consultation rooms and two nurses consultation rooms. The practice team at the surgery is made up of two full time male lead GPs who are partners, one part time female salaried GP completing four sessions per week, two part time locum GPs, a full time female practice nurse and a part time female practice nurse. The practice team also consists of a practice manager, and seven part time administrative and reception staff members. Two practice partners that had worked at the practice for a number of years had both retired in the last six months.

The practice operates under a Personal Medical Services (PMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice reception and telephone lines are open from 8am to 6.30pm Monday to Friday. Appointments are available between 8am and 12pm every morning and 4pm and 6.30pm every afternoon. Extended hours surgeries are offered from 7.30am to 8am on Monday, Tuesday and Wednesday and from 6.30pm to 8pm on Tuesday evening.

The practice has opted out of providing out-of-hours (OOH) services to their own patients between 6.30pm and 8am and directs patients to the out-of-hours provider for Merton CCG.

The practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of diagnostic and screening services, maternity and midwifery services and treatment of disease, disorder or injury.

The practice was previously inspected on 20 May 2014 as part of a pilot, but was not rated. The practice was found to be in breach of regulation 23 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting workers, as staff had not received appraisals.

Detailed findings

Why we carried out this inspection

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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We received information from Merton clinical commissioning group and NHS England. We carried out an announced comprehensive inspection on 27 October 2015. During our visit we spoke with a range of staff including two GPs, a practice nurse, the practice manager and five reception and administration staff. We spoke with eight patients who used the service. We reviewed CQC comment cards completed by 32 patients sharing their views and experiences of the service. We looked at a number of medical records.

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- All staff were aware that significant events should be reported to the practice manager (or the deputy in her absence). The practice's significant event log file was viewed; entries included a detailed description of the event, and details of the lessons learned, actions that would be taken as a result, and a risk assessment which considered the impact of the event and the risk of re-occurrence.
- We were informed that learning from significant events was shared with staff. Both clinical and non-clinical staff we spoke to were able to provide verbal examples of lessons learnt from incidents being implemented and shared. For example following a recent incident, a system had been implemented to keep the reception door locked to ensure staff safety. Although incidents were shared verbally with staff, there was no record to demonstrate how the information was shared.
- The practice had a system in place to record other incidents that were deemed as less significant. A log book was available in the reception area for staff to record and communicate any day to day incidents. Staff were aware of this system and they reported it worked well; however it was not clear whether these incidents were monitored effectively.
- Action was taken to improve safety in the practice as a result of National Patient Safety Alerts (NPSA) and Medicines and Healthcare produces Regulatory Agency (MHRA) alerts. Alerts were sent to the Practice Manager, Deputy Practice Manager, and clinical staff by email. Additionally they were also printed and placed in a file, and staff were required to sign the printed copy to confirm that they had read the alert.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements, and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. All staff were aware of the practice's policies and what to do in the event of a safeguarding concern. There was a lead member of staff for safeguarding children and adults. The GPs attended local safeguarding meetings when possible and we saw evidence to confirm this. The practice also monitored accident and emergency attendances (A&E) during a weekly clinical meeting in order to identify and monitor potentially vulnerable patients. All GPs were trained to level 3 for safeguarding children and the nurses were trained to level 2. All non-clinical staff had completed training to level 1. Additionally, four members of the non-clinical team had attended a Clinical Commissioning Group (CCG) safeguarding and chaperoning course, and the course information was used by one of the GPs to cascade the training to clinical and non-clinical staff during a staff meeting and we saw minutes to confirm this. All staff we spoke with were able to demonstrate a thorough understanding of safeguarding and signs of abuse.
- A notice in the waiting room advised patients that they could request a chaperone if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had received training to equip her for this role. The practice nurse also attended regular nurse forum meetings, where learning and updates related to infection control were shared. There was an infection control policy and supporting procedures in place. Not all staff had received infection control training. We were informed that some clinical and non-clinical staff received training via practice meetings, however there were no records to demonstrate the training that had occurred. Non-clinical staff we spoke with had a clear understanding of their responsibilities in relation to infection control. Infection control audits were undertaken by the practice manager which included most aspects of infection control but did not include a

check relating to staff training. The practice reported they had completed annual infection control audits, however they only kept the most recent audit undertaken. Therefore there was limited evidence to demonstrate the actions taken and improvements made following previous audits. However, the practice manager was able to verbally provide examples of actions taken including changes made to soap dispensers and hand sanitisers.

- The arrangements for managing medicines, including emergency drugs and vaccines in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security).
- The main medicines refrigerator was monitored and maintained appropriately. However we noted that there was a second refrigerator in one of the nurses' consultation rooms, which was used to store any vaccines due to be administered that day. The temperature log demonstrated that on two occasions the recorded temperature was above the required temperature levels, at 14 degrees Celsius. Although we were told no medicines were kept in this refrigerator overnight, there was no record that the abnormal temperatures had been reported and actioned to ensure the cold chain had been maintained. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation and we saw examples of these for childhood vaccinations. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The practice had a thorough recruitment policy in place. We reviewed four personnel files including those for locum staff and found that proof of identification, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service had been carried out. However, the practice did not have a record of interview notes for a recently recruited member of staff.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and a recent health and safety risk assessment had been carried out. The practice had up to date fire risk assessments and carried out regular fire alarm tests and regular fire drills, including a full evacuation drill. Recent fire training had been completed by the nominated fire marshals and we were told by that fire safety was discussed in staff meetings, however there was no evidence to confirm which staff had completed fire safety training. All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. There was no formal assessment in place for the risk of Legionella, although the building was assumed to be low risk. We saw that the practice had started to put processes in place to commence testing for Legionella and they were awaiting the results of this.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and the practice policy was that there were two staff members in the reception area at one time. Administrative staff and reception staff were able to provide cover for each other where required. Regular locum GPs were used if needed.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There were also panic buttons in each clinical room and the reception area which raised an alarm and connected directly to the police.
- All staff apart from one non-clinical staff member had received annual basic life support training. We were told that the practice had followed guidance from the local Clinical Commissioning Group (CCG) that update

Good

Are services safe?

training was required every three years for non-clinical staff. However, the practice had completed a risk assessment to review this immediately after the inspection, in line with recommended guidance.

- There were two emergency medicines bags available; one that remained at the practice and one that GPs took out on home visits. Anaphylaxis kits were available in all treatment rooms. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use, apart from one emergency medicine which had recently expired in September 2015. The practice removed this immediately.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. The practice carried out monthly audits of medicines and equipment, including stocks of oxygen, oxygen masks and defibrillator pads.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and emergency arrangements with a buddy practice. The practice ensured the plan was kept both electronically and in hard copy, and off site copies were kept by the practice manager and partners. The practice had been required to refer to this plan and work with the buddy practice following a bomb scare as the practice was closed. Improvements had been made to the business continuity plan following a review of this incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. NICE guidance was discussed during clinical meetings and during local Clinical Commissioning Group (CCG) meetings. The practice monitored that these guidelines were followed through clinical discussion and random sample checks of patient records.

The GPs had identified roles and led in diabetes, heart disease, dementia and Chronic Obstructive Pulmonary Disease (COPD). The practice nurses assisted with assessing needs of patients with COPD and asthma. From all medical records we reviewed, the practice was found to be following best practice guidance and patients' needs were effectively assessed with the use of annual review templates where relevant. Care plans we viewed included those for patients most at risk of admission to hospital and care plans to support patients over the age of 75s. The practice had completed 158 reviews since April 2015. The practice had signed up to the learning disabilities health check enhanced service in April 2015 and 50% of patients had received a review in the previous six months. There was evidence from all care plans we viewed that they were individualised and patient-centred.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice.) The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results for 2013/14 were 88.5% of the total number of points available, with 2.1% exception reporting. This was below the Clinical Commissioning Group (CCG) and national averages of 93.9% and 94.2 respectively. Results for 2014/15 was 75.1% with 2.9% exception reporting. The practice told us that this data was not reflective of patient outcomes, due to inconsistent coding on the electronic patient record. Records we viewed supported this, as there was evidence that patients were being monitored and managed appropriately, although coding was not always in place to reflect the clinical care that had been undertaken.

Data showed that:

- Performance for diabetes related indicators was similar to the national averages. For example, 73% of patients had well-controlled diabetes, indicated by specific blood test results, compared to the national average of 78%. The number of patients who had received an annual review for diabetes in 2013/14 was 86% which was similar to the national average of 88% and for 2014/15, 81% of patients had received an annual review.
- The percentage of patients with hypertension having regular blood pressure tests was 77% which was similar to the national average of 82% for 2013/14.
- The percentage of patients over 75 with a fragility fracture who were on the appropriate bone sparing medication was 100%, which was above national average of 82% in 2013/14.
- The percentage of patients with atrial fibrillation treated with anticoagulation or antiplatelet therapy was 100%, which was above the national average of 98.32% in 2013/14.
- Performance for mental health related indicators was in line with the national average; 88% of patients had received an annual review in 2013/14 compared with national average of 86%.
- The number of patients with dementia who had received annual reviews was 67% which was lower than the national average of 84% for 2013/14.
- The number of patients with Chronic Obstructive Pulmonary Disease (COPD) who had received annual reviews was 93% for 2014/15.

The practice was also participating in local and national benchmarking, and local data from the CCG indicated that the practice were performing above average for some health promotion activities. We were shown evidence that the partners attended CCG locality meetings where benchmarking data was discussed and shared.

The practice were signed up to the avoiding unplanned admissions enhanced service and had identified 112 patients on their register deemed at risk of admission to hospital. Forty patients on this register had a care plan in

Good

Are services effective?

(for example, treatment is effective)

place so far and the practice had embedded systems in order to monitor all patients on this register. The practice ran weekly clinical meetings to specifically discuss Accident and Emergency (A&E) attendances where at risk patients could be identified. The practice manager and deputy practice manager also reviewed A&E attendances weekly to cross check this against the patients on the register. Administrative staff had received training to ensure that all correspondence related to these most at risk patients on the register was set aside, so that discussions could be held between the practice manager and GPs to ensure they were updated with regards to any changes in their care and treatment. GPs then followed up patients on the register that had presented to A&E and we saw examples of this.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. There had been four clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored. For example, in 2015, following recent NICE guidance for Omega-3 supplements, the practice had identified 12 patients who were taking these supplements that did not require them and reviewed the audit again to monitor Omega-3 prescribing. The practice also took part in an antibiotics prescribing audit as a result of reviewing their prescribing data.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice did not have an induction policy but they utilised a checklist for newly appointed staff and non-clinical staff reported they had experienced a thorough induction process. Induction arrangements included training to use the practice computer systems effectively. Induction processes also included arranging mandatory training for staff including safeguarding children, basic life support, confidentiality and information governance, however it was not clear from staff files when staff had completed the required training.
- Clinical and non-clinical staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. We were shown that all staff were in the process of completing information governance e-learning modules.
- Role-specific update training for clinicians included training for diabetes, COPD, smoking cessation, cervical screening and immunisations. Some clinical staff members had received training in the Mental Capacity Act and had disseminated this training to clinical and non-clinical staff in the practice.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Most staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, appraisals, clinical supervision and facilitation and support for the revalidation of doctors. The practice nurse attended the local practice nurse forum to seek peer support. The practice nurses and salaried GP received clinical supervision sessions every two weeks from the partners in the practice, which had recently commenced.
- All staff had received appraisals annually.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services efficiently, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. The practice had good systems in place to ensure that test results were dealt with quickly. The practice had recently commenced the use of an electronic document management system and staff reported that this system improved the management of correspondence received into the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice used a 'day book' system located in the reception area to ensure that all messages were communicated between clinical and non-clinical staff. All staff we spoke with reported that this system worked well.

We saw evidence that multi-disciplinary team meetings with district nurses, social services and the palliative care team took place on a monthly basis and that care plans were routinely reviewed and updated. The monthly meeting reviewed patients on the practice's palliative register and detailed minutes where shared with the relevant team members. The practice also ran a weekly clinical meeting to discuss Accident and Emergency (A&E) attendances so at risk patients could be monitored.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear, the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, patients over the age of 75, those at risk of developing dementia, patients with a learning disability and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. Health promotion was encouraged via use of prescriptions and text messages.

The practice hosted a psychological therapy service one day a week and were able to refer patients to this service. Smoking cessation advice was available from the practice nurses. The practice had performed above local average for their smoking cessation success rate, achieving 60% of their target which was the second highest success rate in the Clinical Commissioning Group (CCG) for 2014/15.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 75% for 2013/14, which was below the national average of 82% but had improved to 78% for 2014/15. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data showed there was a 56% uptake for bowel cancer screening in April 2015 which was the third highest in the CCG and a 62% uptake for April 2014 which was the highest achieving practice in the CCG.

Childhood immunisation rates for the vaccinations given were above or in line with CCG averages for 2013/14. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 72% to 98% and five year olds from 81% to 96%, which were all above CCG averages. Benchmarking data for 2014/15 showed that the practice were the highest performing practice in the CCG for the five in one vaccine for those under 12 months, achieving 99%.

Flu vaccination rates for the over 65s were 64%, and at risk groups 47% for 2013/14. These had improved to 65% and 49% for 2014/15. These were below national averages. Patients with diabetes who had received the flu vaccination was at 82% for 2013/14 which was lower than the national average of 93%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area next to the reception desk to discuss their needs.

All of the 32 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with eight patients on the day of our inspection, including one patient who was joining the Patient Participation Group (PPG). They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required and 10 comments cards specifically commended the excellent care received from the nursing team.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice scored the highest in the CCG for patients' overall experience. The practice was well above average for its satisfaction scores on consultations with doctors; however the practice was below average for its satisfaction scores on consultations with nurses. Data showed that:

- 95% describe the overall experience as good compared with a Clinical Commissioning Group (CCG) average of 79% and a national average of 85%.
- 95% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 93% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82% and national average of 85%.
- 88% said the nurse was good at listening to them compared to the CCG average of 88% and national average of 91%.
- 84% said the nurse gave them enough time compared to the CCG average of 88% and national average of 92%.
- 92% said they had confidence and trust in the last nurse they saw compared to the CCG average of 96% and national average of 97%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.
- 91% find the receptionists at this surgery helpful compared with a CCG average of 84% and a national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 92% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 83% and national average of 86%.
- 86% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81%.
- 82% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 90%.

Good

Are services caring?

- 79% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and 19% of the practice list had been identified as carers. The practice reported they were in the process of updating their carers register. Carers were being supported, for example, by offering health checks and referral for social services support and they were given a direct contact number to the practice prescriptions clerk so that they were able to order repeat prescriptions easily. Written information was available for carers to ensure they understood the various avenues of support available to them. One patient we spoke to was a carer and confirmed they had been given support by the practice.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

One of the partners attended the local CCG meetings on a regular basis. The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. For example, the practice was part of the CCG pilot project for near-patient testing, which involved carrying out tests for patients at the practice that would normally require admission to Accident and Emergency (A&E). The practice showed us a recent example of where they had carried out a deep-vein thrombosis tests and as a result, patients did not have to attend A&E for this to be completed. The practice were the CCG agreed host site for the psychological therapy service one day per week. Patients from all practices in the CCG were able to access this service.

The practice had worked with the local Healthwatch team to establish a Patient Participation Group (PPG). This was still in the process of being developed, but there were some identified members and meeting dates had been set.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered extended hours on a Monday, Tuesday and Wednesday morning from 7.30am until 8am and Tuesday evening from 6.30pm until 8.00pm for working patients who could not attend during normal opening hours.
- The practice offered an over 75's health check and provided 30 minute appointments for these patients either at the practice or via a home visit.
- The practice offered a six week baby clinic and post-natal checks for mothers at eight weeks.
- There were longer appointments available for patients who needed extra support such as people with dementia and those with a learning disability.
- Home visits were available for older patients and housebound patients who would benefit from these.
- Urgent access appointments were available daily with each GP for all children, older patients, those at risk of admission to hospital and those with serious medical conditions.
- All staff were aware of the most vulnerable and at-risk patients registered with the practice. The practice held a register of vulnerable children, vulnerable adults, housebound patients and those at risk of unplanned admissions to hospital.
- All patients had a named GP and it was practice policy to ensure that routine and emergency appointments were booked with the same GP for continuity of care.
- The practice provided a direct contact number for repeat prescriptions for vulnerable patients, including those with cancer, housebound patients and carers so patients could receive their prescriptions in a timely manner.
- The practice was able to register homeless patients and temporary patients. Staff told us about a patient that had been registered temporarily so that they could access emergency treatment from the practice.
- There were baby changing facilities, disabled facilities, a hearing loop and translation services available. The practice website could be viewed in different languages.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8am to 12pm every morning and 4pm to 6.30pm in the afternoon. Extended hours surgeries were offered from 7.30am to 8am three days a week and 6.30pm to 8pm on Tuesday evening. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. We saw that the practice had a number of urgent appointments available on the inspection day and the next pre-bookable appointment with a GP was available in one week and within three days with a practice nurse.

Patients were able to access appointments and repeat prescriptions via online services and patients received appointments reminders and a cancellation facility via text message.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages and people we spoke to on the day were always able to get appointments when they needed them. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 76% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 70% and national average of 75%.
- 91% patients said they could get through easily to the surgery by phone compared to the CCG average of 60% and national average of 73%.
- 88% describe their experience of making an appointment as good compared with a CCG average of 66% and a national average of 73%.
- 95% say the last appointment they got was convenient compared with a CCG average of 88% and a national average of 92%.
- 67% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 55% and a national average of 65%.
- 69% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 50% and a national average of 60%.

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 in the patient waiting area where posters were displayed and complaints information was included on the practice website.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled, acknowledged and responded to in a timely way and there was evidence of openness and transparency in dealing with complaints.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a complaint about delays in getting urgent hospital treatment was discussed between all clinicians and improvements were made to the patient pathway so that urgent referrals would be made for future patients presenting with the same condition. The practice had discussed this at a clinical meeting and staff we spoke with were aware of the actions taken; however complaints shared with staff were not consistently documented in meeting minutes.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had discussed their vision and strategy with staff and all staff we spoke with were aware that the practice was looking towards better ways of working by integration with local GP practices whilst maintaining continuity of care for patients and also a vision to improve Quality and Outcomes Framework data by improving the practice's use of the electronic record system. The practice did not have their strategy formally documented however.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. Governance structures and procedures in place included:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff on the practice's shared drive or via paper copies for reception staff so polices could be accessed easily. All staff knew how to locate policies and policies we viewed had all been updated to reflect any changes in governance in the practice.
- There was a comprehensive understanding of the performance of the practice. The partners attended Clinical Commissioning Group (CCG) meetings where performance data was shared. Two long-standing GP partners retired in 2015 and the partnership had changed recently with a new partner joining the practice. The two GP partners met with the practice manager monthly to discuss practice performance and to identify areas for improvement. The new partnership had identified and commenced changes to address identified gaps, including refining the practice's repeat prescribing policy in line with recognised guidance, addressing areas of lower Quality and Outcomes Framework (QOF) performance and improving use of coding in the practice, current recruitment of a new administrative staff member to support information technology systems in the practice and the introduction of structured clinical supervision sessions for practice nurses and the salaried GP.
- Clinical audits were used to monitor quality and to make improvements, by linking audits to practice performance, however a clinical audit plan had not yet been developed.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice were in the process of transferring management of human resources and health and safety to an external company to assist with good governance of these systems. The practice had identified most risks to patient and staff safety, however it was not always clear how actions from identified risks were followed up or shared with staff, for example from infection control audits and reported incidents.
- Systems for monitoring and recording staff training were not always clear. Some training evidence was visible in staff files, recorded in meeting minutes, or in a training log, but it was not fully collated to provide a clear overview.

Leadership, openness and transparency

The partnership had undergone change within the last year. The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty which was clear from speaking to all staff, many of whom had worked at the practice for a number of years. Staff said they felt respected, valued and supported, particularly by the practice manager and partners. Staff told us that they were very supportive of the changes that the partners had made and were looking forward to the future development of the practice.

Regular team meetings were held and we saw meeting minutes to demonstrate that all staff meetings were held monthly or more frequently if required. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. All staff had received an annual

Are services well-led?

Good

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

appraisal. The practice had a range of human resources policies and procedures in place to support staff, such as whistleblowing. The practice provided all staff with a staff handbook.

Seeking and acting on feedback from patients, the public and staff

The practice gathered feedback from patients through comments and suggestions and use of the NHS Friends and Family Test (FFT). Results from the FFT since April 2015 were 100% positive. The practice were aware of the national GP patient survey results published in July 2015 and we were shown an action plan put in place to address any concerns identified.

The practice had previously had a virtual Patient Participation Group (PPG) however this had not been active since 2013, after the last practice patient survey had been undertaken. An action plan had been developed following this survey with some action points addressed such as improving availability of PPG information on the practice website. Although the practice did not have an active PPG at the time of the inspection, the practice were able to provide us with information to show that they were currently working with Healthwatch Merton to develop a formal PPG. We saw that a plan had been developed with key milestones, some of which had been achieved. The first PPG meeting was scheduled for November 2015 and during the inspection we spoke with a newly recruited PPG member who confirmed the progress of the group. The practice had recruited PPG members at the time of the inspection.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, for example, an administrative staff member told us that they were involved in improving the repeat prescription process for the practice in conjunction with clinical staff.

Innovation

There was evidence that the practice had identified and made recent changes to improve practice systems and there was a drive towards learning and improvement at all levels within the practice. The practice team had made changes in clinical supervision for clinical staff and were working with the local Healthwatch to ensure the new Patient Participation Group (PPG) was set up effectively.

The practice were part of local schemes to improve outcomes for patients in the area including near patient testing, to reduce the need for Accident and Emergency (A&E) attendances.