Lambeth Walk Group Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Lambeth Walk Group Practice provides primary medical services to approximately 7,400 patients in the London borough of Lambeth. This is the only location operated by this provider, a partnership that was created in 2006.

We visited the practice on 19 November 2014 and carried out a comprehensive, announced inspection of the services provided.

The practice is rated as "good" overall. Whilst we found some areas that require improvement, we also found some examples of outstanding care being provided. The practice was rated as "outstanding" for its responsiveness, "good" for its effectiveness, leadership and how caring it was to its patients. However, the practice "requires improvement" for safety.

Our key findings were as follows:

- Patients were mostly positive about the practice and the services provided. The daily walk-in clinic meant that people could see a GP when they needed to and extended opening hours were offered three mornings a week, which particularly suited those of working age.
- Some systems were in place to keep people safe; there was a system for reporting incidents, responding to safeguarding concerns and managing medicines safely. However, we found some improvements were needed in relation to infection control, recruitment procedures and ensuring lessons learnt from incidents were documented and disseminated widely.
- Staff were appropriately qualified to deliver effective care. It was a training practice for trainee GPs as well as providing training to undergraduate medical students. The practice's performance against clinical outcomes and patient experience was either in line with or above other practices in the area.

Summary of findings

- The practice proactively worked and engaged with third party organisations to meet the emotional well-being of their patient group. Some of this work was outstanding.

We saw several areas of outstanding practice including:

- The practice had won the Royal College of General Practice's Quality Practice Award in 2013, which is the highest award attainable. It involves the participation all practice staff and thus recognises the team's commitment to reflection, learning and improving in order to provide quality care. Practices are judged against six modules which examine how the practice ensures it is patient-centred, how it meets the needs of different groups, how it manages illness and how it is a learning organisation.
- The practice had undertaken an audit in 2013 for patients with high blood pressure to assess whether their medicines were being optimised. The results confirmed that the number of patients with well treated hypertension had improved as a result of actions taken following an initial audit in February 2013. A re-audit in November 2013 found that 95% of patients in the audit now had blood pressures within the recommended range, an increase from 60%.
- The practice was outstanding in how it responded to the needs of its patients, which were central to the planning and delivery of care. It had been innovative and proactive in its approach to healthcare, recognising the importance of meeting a patient's emotional needs as well as their physical needs, organising initiatives at the practice and signposting patients to activities and groups within the community. The practice was the first in Lambeth to have a reading group and the first to develop a gardening co-operative where patients can come and grow vegetables in the practice garden with the aim of providing other health services in the area. An annual Christmas party was held for patients aged over 80. In addition, the practice had recently engaged with a voluntary organisation that promoted mental well-being through creativity and hosted sessions at the practice.
- The practice had begun to produce information and correspondence in large font for those that required it.
- There were outstanding examples of multidisciplinary working for patients with diabetes and chronic obstructive pulmonary disease (COPD). Virtual clinics were held with community nurse specialists and a hospital consultant during consultations with complex patients.
- The practice offered extended opening hours three mornings a week from 07:00 to 08:00 to meet the needs of patients that worked. These appointments were heavily utilised by this population group.

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

Importantly, the provider must:

- Ensure that the appropriate pre-employment checks are carried out before staff commence work at the practice. Ensure that all staff acting as chaperones have had a Disclosure and Barring Service check.
- Ensure there are appropriate systems and processes in place to protect people from the risk of infection and that all single-use items are within their expiry date.

In addition the provider should:

- Ensure that all nursing and administrative staff are appraised annually and that personal development plans are in place.
- Review the roles and responsibilities of the management team to ensure leadership is as effective as it can be.
- Ensure clinical meeting minutes contain sufficient detail of the discussion so that it is clear what action is required and by which individual.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found gaps in recruitment checks and staff acting as chaperones had not had a criminal records check. Whilst the practice had an infection control policy in place and staff had received relevant training, the policy was not fully adhered to. Checks were not always recorded or thorough; we found out of date single-use items during the course of our inspection.

Are services effective?

Good

The practice is rated as good for providing effective services, but we found some areas that were outstanding. In 2013 the practice had won the Royal College of General Practice's Quality Practice Award, which measures performance against clinical outcomes and patient experience. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. Clinical audits had been carried out and the practice was able to demonstrate how this had led to improvements in patient outcomes. For example, 95% of patients with hypertension had blood pressures within the recommended range following a review of their medicine dosages. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Most staff had received training appropriate to their roles and any further training needs have been identified and planned. Whilst the GPs and practice nurse practitioner had received annual appraisals, the remaining staff had not been appraised since April 2013. Staff worked with multidisciplinary teams, including district nurses, health visitors, community nurse specialists and hospital consultants to ensure patients received effective, co-ordinated care.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than other practices for several aspects of care. Patients said they were treated

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with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand and in a format that met their needs. The practice took a holistic approach to patient care, understanding the importance of meeting their emotional and social needs as well as their physical needs. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. People's individual needs and preferences were central to the planning and delivery of care. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, it had obtained funding for a gardening co-operative and engaged with a voluntary organisation that promoted mental well-being through creativity.

Patients could access appointments and services in a way and at a time that suited them. 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 residential care homes who the practice provided GP services to told us GPs were quick to respond and provided good continuity of care.

The practice had good facilities and was well equipped to treat patients and meet their needs. There were a variety of clinics available and staff engaged with specialists where appropriate. For example, there were joint diabetic reviews with the community Diabetic specialist nurse and a hospital consultant. They were also available for virtual consultations with the practice nurse practitioner to discuss more complex patients during their appointment. Virtual consultations were also available for complex COPD patients. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was some learning from complaints with staff and other stakeholders.

Are services well-led?

Good 

The practice is rated as good for being well-led. There had been a high turnover in practice manager staff and GPs since the partnership was formed in 2006. As a result, we found that some systems and process relating to the management of the practice, such as recruitment, appraisal and risk management had not been completed. However, during our inspection it was clear that the current management team had taken steps to address the issues and acknowledged those that remained outstanding.

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The practice had a vision and a strategy, which staff could articulate. Staff were clear of their roles and responsibilities and were aware who they should approach in the senior management team with specific issues. Staff were positive about working at the practice and described it has having an open culture. The practice had a number of policies and procedures to govern activity, and there were weekly meetings to monitor performance. The practice actively sought feedback from patients and had a patient participation group (PPG). However, this was not self-managing and was currently used more as a forum for the practice to disseminate messages. All staff had received inductions but not all staff had received regular appraisals. Staff told us they felt well supported and sufficiently trained.

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. The practice had a higher proportion of patients over 75 (6% of its patient list) compared to other practices in the area. 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 patients in its population and had a range of enhanced services, for example, in dementia and end of life care.

It was responsive to the needs of older people, offering home visits and recognising that social isolation is a risk factor for this population group. For example, an annual Christmas party was held by the practice for its patients aged 80 years and over. Rapid access appointments were made available for those in this population group who had been identified as having particular needs. The practice also provided primary care services to a local residential home caring for frail older patients and patients with dementia. One of the GP partners performed a weekly ward round at the home and was involved in multi-disciplinary care planning meetings. The manager of the residential home was complimentary about the practice and the service they received.

As of February 2014 70% of patients aged 65 and older had received a seasonal flu vaccination, which was slightly below the national average of 73%. The administrative team were working with the practice nurses to improve uptake in this population group for example, those who had mobile phones were being sent text message reminders for their appointments.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher proportion of patients (63%) with a long-standing health condition compared to other practices in the area. 19% of patients were categorised as having a long-term condition, such as diabetes, asthma or chronic obstructive pulmonary disease (COPD). There were lead GPs for different clinical conditions and the practice held a variety of specific clinics, including diabetic and COPD clinics. We spoke with two patients who had a long-term condition and they felt they were supported to manage their condition.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly and we were told of

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a recent example when these processes had been utilised. Longer appointments and home visits were available when needed. All patients in this population group had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. For example, there were joint diabetic reviews with the community Diabetic specialist nurse and a hospital consultant. They were also available for virtual consultations with the practice nurse practitioner to discuss more complex patients during their appointment. Virtual consultations were also available for complex COPD patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Approximately 19% of the practice's patients were under 19 years of age. 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 A&E attendances and those who failed to attend their childhood immunisations or baby checks. Immunisation rates were similar to other practices in the area. Parents could make a pre-booked appointment or attend the weekly walk-in baby clinic where they could also see a GP or a health visitor.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Children under the age of one or any child with a high temperature were prioritised for an appointment to see a GP.

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. For example, the practice offered appointments from 07:00 to 08:00 three mornings a week to meet the needs of this population group. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding 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, travellers and those with a learning disability. It had carried out annual health checks for all people with a learning disability and these were offered longer appointments.

The practice aimed to reduce all barriers to accessing healthcare and did not make it a requirement to provide a proof of address to register with the service. It worked closely with local churches and food banks, offering food vouchers to patients on a low income.

The practice engaged with other organisations and professionals to support patients, including those that may be vulnerable. For example, a representative from the Citizens Advice Bureau held appointments at the practice two sessions a week and a drugs and alcohol counsellor attended weekly. Staff had also received training in domestic abuse. We were given examples by staff of where they had intervened when they had identified a person who was vulnerable. These interventions included arranging an appointment for them to see a GP straight away, referrals to specialist services, domestic abuse information and referrals to social services.

There were arrangements in place to provide interpretation services for patients who did not speak English. The practice also encouraged patients to attend English classes to help them better access services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had 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)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Lambeth has one of the highest prevalence rates of severe mental illness in London and 11% of the practice's patients had a mental health condition. We found that the practice was proactive and innovative in the way they cared for this population group, recognising the importance of meeting a patient's emotional needs as well as their physical needs. The practice was the first in Lambeth to have a reading group and the first to develop a gardening

co-operative where patients can come and grow vegetables in the practice garden with the aim of providing vegetables to other health services in the area. The practice had recently engaged with a voluntary organisation that promoted mental well-being through creativity.

Over 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive, agreed care plan documented in their record in the last 12 months. This is significantly higher than the national average of 86%. 82% of patients with a mental health condition had received a physical health check in the last year. 90% of patients diagnosed with dementia had received a face-to-face review in the last 12 months, compare to the national average of 83%.

A psychologist attended the practice weekly for appointments with patients who had been referred by their GP. The practice also had access to onsite specialist psychotherapy services, including cognitive behaviour therapy (CBT). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. For example, the practice worked with two homes, including one that provided specialist care to patients with complex mental illnesses. The GPs met with the clinical staff at the home regularly to discuss specific cases. In addition, community psychiatric nurses (CPN) also attended the practice's clinical meetings.

Clinical staff had received training on how to care for people with mental health needs and dementia. GPs carried out advance care planning for patients with dementia. One of the administrative staff had received training on dementia and had been appointed as the practice's Dementia Friend with the aim of providing support and signposting for carers of patients with dementia.

Summary of findings

What people who use the service say

We received 11 completed Care Quality Commission (CQC) comments cards providing feedback about the service. We also spoke with nine patients and two representatives of the practice's patient participation group (PPG) on the day of our inspection. Most patients were positive about the service they experienced. Patients said they felt the practice offered a pleasant service and staff were helpful, supportive and caring. They said staff treated them with dignity and respect, listened to them and met their needs. They also felt they were treated in a clean and comfortable environment. This supported the findings of the national patient survey where the proportion of patients who felt listened to by their GP and that they had received clear explanations was better than the CCG average.

Members of the PPG we spoke with supported the idea of a having a PPG and stated that whilst they appreciated the openness of the practice, they were not involved in setting the agenda of the meetings. The feedback from the members indicated that the PPG was practice-led, rather than patient-led. The practice was aware of this and were in the process of recruiting a patient to chair the group. We looked at the patient survey of 378 patients conducted by the practice in March 2014. We saw the practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of the feedback from the survey. These included the introduction of a daily walk-in clinic and producing information in large font for those patients who required it.

Areas for improvement

Action the service MUST take to improve

- Ensure that the appropriate pre-employment checks are carried out before staff commence work at the practice.
- Ensure that all staff acting as chaperones have had a Disclosure and Barring Service check.
- Ensure there are appropriate systems and processes in place to protect patients from the risk of infection and that all single-use items are within their expiry date.

Action the service SHOULD take to improve

- Ensure that all nursing and administrative staff are appraised annually and that personal development plans are in place.
- Review the roles and responsibilities of the management team to ensure leadership is as effective as it can be.
- Ensure clinical meeting minutes contain sufficient detail of the discussion so that it is clear what action is required and by which individual.

Outstanding practice

We found the following examples of outstanding practice during our inspection:

- The practice had won the Royal College of General Practice's Quality Practice Award in 2013, which is the highest award attainable. It involves the participation all practice staff and thus recognises the team's commitment to reflection, learning and improving in order to provide quality care. Practices are judged against six modules which examine how the practice ensures it is patient-centred, how it meets the needs of different groups, how it manages illness and how it is a learning organisation.
- The practice had undertaken an audit in 2013 for patients with high blood pressure to assess whether their medicines were being optimised. The results confirmed that the number of patients with well treated hypertension had improved as a result of

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actions taken following an initial audit in February 2013. A re-audit in November 2013 found that 95% of patients in the audit now had blood pressures within the recommended range, an increase from 60%.

- The practice was outstanding in how it responded to the needs of its patients, which were central to the planning and delivery of care. It had been innovative and proactive in its approach to healthcare, recognising the importance of meeting a patient's emotional needs as well as their physical needs, organising initiatives at the practice and signposting patients to activities and groups within the community. The practice was the first in Lambeth to have a reading group and the first to develop a gardening co-operative where patients can come and grow vegetables in the practice garden with the aim of providing other health services in the area. An annual Christmas party was held for patients aged over 80. In addition, the practice had recently engaged with a voluntary organisation that promoted mental well-being through creativity and hosted sessions at the practice.
- The practice had begun to produce information and correspondence in large font for those that required it.
- There were outstanding examples of multidisciplinary working for patients with diabetes and chronic obstructive pulmonary disease (COPD). Virtual clinics were held with community nurse specialists and a hospital consultant during consultations with complex patients.
- The practice offered extended opening hours three mornings a week from 07:00 to 08:00 to meet the needs of patients that worked. These appointments were heavily utilised by this population group.

Lambeth Walk Group Practice

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, a CQC Inspector, a Practice Manager and an Expert by Experience.

You should also be aware that experts who take part in the inspections, for example, Experts by Experience, are not independent individuals who accompany an inspection team – they are a part of the inspection team and should be described in that way. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Lambeth Walk Group Practice

Lambeth Walk Group Practice provides GP services to approximately 7400 patients in Lambeth from a single location. The practice has a Personal Medical Services (PMS) contract. PMS agreements are locally agreed contracts between NHS England and a GP practice. The practice provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning, contraception services, minor surgery and counselling.

The practice is located in an area of high deprivation where the life expectancy for men and women is 76 years and 82 years respectively, which is in line with the national average. Over 63% of patients have a long-standing health condition, compared to an average for the Clinical Commissioning Group (CCG) of 46%. The majority of the practice's patients are aged between 20 and 59 years old (65 percent); approximately 19% are under 19 years old and 15% are over 60. According to data held by the practice, the patient population it serves is ethnically and culturally diverse, including British, African, Caribbean, White Other, Indian and Chinese patients. The largest group is British, accounting for 30% of patients.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: treatment of disease, disorder or injury; family planning; maternity and midwifery services; surgical procedures; and diagnostic and screening procedures.

The practice is designated as the GP practice for King's College London University, providing teaching to undergraduate medical students.

The practice is currently open five days a week from 08:00 am to 18:30 pm with both booked appointments and a daily walk-in clinic. In addition, the practice offers extended opening hours from 7:00am to 8:00am on Monday, Tuesday and Wednesday mornings for pre-booked appointments.

The surgery is a GP training practice, and has two partners and four salaried GPs (4 male and 2 female) who are either full or part-time. One of the female GPs works one session a week. Both GP partners are now accredited GP trainers. There is a nurse practitioner (0.6 whole time equivalent (WTE)), a practice nurse (0.8 WTE) and one healthcare assistant (full time). The practice has a practice manager and an administration team of eight, including reception staff, some of whom are part time.

The practice has out of hours (OOH) arrangements in place with an external provider and patients are advised that they can also call the 111 service for healthcare advice.

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.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with Lambeth Clinical Commissioning Group (CCG), NHS England and Healthwatch. We carried out an announced visit on 19 November 2014. During our visit we spoke with a range of staff, including three GPs, two medical students, the practice Nurse Practitioner, the Healthcare Assistant (HCA), the practice manager and administrative staff. We also spoke with a psychologist, a Health Visitor and a member of a voluntary organisation who hold sessions at the practice. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 11 comment cards where patients and members of the public shared their views and experiences of the service and we spoke with nine patients and two members of the practice's patient participation group (PPG).

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. These groups are:

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

People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there had been a near miss when a patient had not received a hospital appointment following an urgent referral from the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We were told that the practice did not categorise incidents or events, but recorded them all as a "significant event". We reviewed five significant event reports, which was the total number on record between 13.12.2013 and 16.10.2014. We found that some of the reports were incomplete and in different formats, so it was not clear what actions had been taken, what learning had been identified and whether these had been shared with the practice team as a whole. One recently reported event involved the missed home visit of a housebound patient. Staff were reminded to check the list of allocated home visits during each session and the duty GP was responsible for ensuring these had been completed in the afternoon. The practice manager's log of significant events summarised the action taken, but it was only documented that it was discussed at a clinical meeting. There was no formal record when the learning was shared with non-clinical staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Most were aware of incidents that had occurred, but not all could describe what lessons had been learnt as a result.

National patient safety alerts were disseminated to practice staff via email or in person by the practice manager or lead GP partner, the nominated leads. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, we saw evidence that a recent alert on Ebola had been shared with staff via email and discussed at practice meetings. In response to the alert, the practice had developed a policy, added a message for patients on its website and changed the voicemail message on its telephone system to inform patients what to do if they had concerns.

Lambeth CCG had an electronic system that services could use to instantly submit safety quality alerts, incidents or commendations about providers or individuals. The practice gave examples of when they had used this reporting system.

Reliable safety systems and processes including safeguarding

One of the GP partners was the safeguarding lead for the practice and all staff we spoke with knew who the nominated person was. There were child protection and safeguarding policies and procedures in place, which were available to all staff electronically. Staff knew how they could access them if needed and were able to describe the process for reporting any safeguarding concerns.

There was some confusion about which staff had received child protection training and safeguarding adults training. All GPs had received Level 3 child protection training and safeguarding adults training. Whilst we were told that the nurses and administrative staff had received Level 3 and Level 1 child protection training respectively, there were no records to confirm this. However, all the staff we spoke with were able to demonstrate a level of competency that would be suitable for their role and described the action they had taken when they had had safeguarding concerns. All staff had attended training on domestic violence.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, such as children subject to child protection plans or those whose circumstances made them vulnerable. The health visitor who was attached to the practice told us they were informed by staff if parents persistently failed to bring their child in for their immunisations.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. We were told that some administrative staff acted as chaperones. One member of staff had attended formal chaperone training and had shared this learning with the remaining staff. They were also given informal training by the GPs at the practice and they were able to describe what

the role of a chaperone entailed. However, a Disclosure and Barring Service (DBS) check had not been undertaken for all staff who acted as chaperones. The practice's DBS policy stated that non-clinical staff did not need to have a DBS check, but it had not considered those acting as chaperones.

Cleanliness & Infection Control

We observed the premises to be clean and tidy on the day of our visit. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice was cleaned every evening by cleaning contractors. We saw there were cleaning schedules in place. Whilst consultation room were carpeted, they were deep cleaned monthly, along with the treatment rooms.

The practice nurse practitioner was the lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. There was an infection control policy, which stipulated that weekly and monthly cleaning checks would be completed along with random spot checks. Staff told us they carried out regular checks, but these were not recorded. The practice's policy also stated that a comprehensive infection control audit would be undertaken every six months. Whilst we saw an audit had been completed in September 2014 and areas for improvement identified and acted upon, the last recorded audit prior to that was from March 2011.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury. The practice used single-use disposable instruments. However, when we inspected the treatment rooms we found sterile items, such as swabs and needles that had passed their expiry date. Two swabs had expired in 2008 and approximately 50 needles had expired in 2013. These were immediately disposed of by the practice and we were assured they would be included in future checks. The practice's infection control audit completed in September 2014 had not included checking such items. There were appropriate arrangements in place for the safe storage and disposal of clinical waste.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However, the soap dispenser in one of the patient toilets was empty and this was not replenished during the course of our inspection.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Adult and child vaccines were segregated in two separate fridges as an additional safety measure. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using Patient Group Directions (PGD) that had been produced in line with legal requirements and national guidance. A PGD is a specific written instruction for the supply and administration of a licenced named medicine to specific groups of patients who may not be individually identified before presenting for treatment. A member of the nursing staff (Practice Nurse Practitioner) was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed. She told us she only prescribed medicines she was competent to do so.

We saw that the practice policy for repeat prescriptions was in line with national guidance. A review of 20 patients receiving repeat prescriptions confirmed that medication reviews were taking place in a timely manner and were being correctly recorded in the medical records.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken

based on the results. We checked five anonymised patient records which confirmed that the procedure was being followed and that recommended blood test monitoring was being undertaken.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment, for example blood pressure monitors. The practice had decided not to undertake Portable Appliance Testing following a risk assessment of all equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff, including the pre-employment checks that should be carried out. We looked at six staff files and found the practice had not followed its own policy and had failed to carry out the necessary recruitment checks on all staff prior to their employment or carry out checks that were appropriate for their roles. For example, two clinical staff files did not contain records of a Disclosure and Barring Service (DBS) check and one did not record their Hepatitis B status. In another member of staff's file only one verbal reference had been sought rather than two written references.

The practice had a DBS policy which stated that only clinical members of staff should have a criminal records check as they came into direct contact with patients. However, some non-clinical staff were acting as chaperones, but no DBS check had been carried out. Clinical members of staff were required to sign a declaration each year stating that there had been no change to their criminal record. Whilst these had been signed by staff, they were not fully completed and did not include the date of their original DBS check and there were no records to assure us these had been done for all relevant staff. It is recommended that DBS checks should be undertaken every three years for all clinical staff and for all non-clinical staff who had direct contact with patients and those undertaking the duties of a chaperone.

We saw that systems were in place to ensure levels of staffing were responsive to changes in demand. As well as a daily rota, there was an arrangement in place for members of staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Both GP partners had one "non-clinical" day a week, but they would be present at the practice and able to see patients, if required.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. There was a comprehensive health and safety policy and a variety of risk assessments had been completed, including in relation to fire, legionella and clinical waste.

Staff were able to describe how they identified and responded to changing risks to individual patients including deteriorating health and well-being or medical emergencies. For example, the practice nurse had recently seen a patient with low blood oxygen saturation levels who they nebulised before calling an ambulance.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, there were weekly clinical meetings which were attended by other relevant professionals on a rotational basis to discuss patients with complex needs. The practice had also identified those patients who were at high risk of hospital admission or accident and emergency attendance and produced individual care plans in order to prevent such admissions. The practice kept a register of those patients receiving end of life care, which was shared with the practice's out of hours provider. The practice also informed the out of hours provider of any patients who may require their support via an alert system.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen, a nebuliser and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked

members of staff, they all knew the location of this equipment and we noted that daily checks on the emergency equipment had commenced in the week preceding our inspection.

Emergency medicines were also available and there were processes in place to check they were within their expiry date and suitable for use. All the medicines we checked were in date, but were not always securely stored. We noted that there was an anaphylaxis kit in each consultation room, but these were on display and could be easily removed by an unauthorised person. The risk of this happening had not been assessed by the practice.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety, including fire drills and fire safety training for staff. The practice had put control measures into place to minimise identified risks. The owner of the building was responsible for testing and maintaining the fire system, which was tested weekly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence, the British Medical Journal, the British Journal of General Practice and from local commissioners. We saw minutes of management and clinical meetings where new guidelines were discussed and disseminated. The implications for the practice's performance and patients were discussed on a monthly basis and required actions agreed. New guidelines were also discussed bimonthly at locality meetings with the neighbouring 11 GP practices. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. A review of 20 clinical records confirmed that patients with high blood pressure and irregular heartbeats (atrial fibrillation) were receiving treatment in line with recent NICE guidance.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. There were daily informal meetings between clinical staff for peer advice on specific cases and weekly clinical meetings where complex cases were discussed with other relevant professionals.

The GPs told us they lead in specialist clinical areas such as diabetes, mental health and minor surgery and practice nurses supported this work. One of the partners undertook a limited list of minor surgical procedures. The practice referred more serious procedures to a nearby GP practice who had both accreditation and facilities to undertake these procedures. The practice offered a cryotherapy service.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and improve outcomes for patients, including identifying those who may be high-risk, benchmarking performance and completing clinical audits. The practice used computerised tools to identify patients with complex needs who required care plans to be documented in their case notes in line with the National Enhanced Service (ES) guidance. The practice had completed the requirements for payment under this ES by delivering care plans for the required 2% of the target population. The practice wrote to all those identified patients and developed Admission Avoidance Care Plans in collaboration with them.

The practice was in close proximity to an Accident and Emergency department (A&E) and recognised that a relatively high number of patients attend A&E when they could have attended the surgery. The practice wrote to patients who attended A&E during surgery opening hours to inform them of the services offered by the practice to try and decrease the number of A&E attendances. The practice's A&E attendance rate was similar to other practices in the area and only slightly higher than the national average.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that suggestions for improvements to practise were shared with all clinical staff. We were shown the process the practice used to review patients recently discharged from hospital. The practice had a clear policy for the GPs to contact patients on a needs basis following clinically or socially significant admissions.

Lambeth CCG is in the top 10 Nationally when rated for prescribing effectiveness .The practice's antibiotic prescribing rates were similar to other practices in the CCG area and had continued to improve in the last two years. The practice had audited its antibiotic prescribing for patients with urinary tract infections initially in June 2013 and subsequently in October 2013 and finally in October 2014. We saw evidence that learning had been shared and that prescribing had become more closely aligned to local guidance as a result of the audit.

The practice had also undertaken a completed audit in 2013 for patients with high blood pressure to assess

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(for example, treatment is effective)

whether their medicines were being optimised. The results confirmed that the number of patients with well treated hypertension had improved as a result of actions taken following an initial audit in February 2013. A re-audit in November 2013 found that 95% of patients in the audit now had blood pressures within the recommended range, an increase from 60%. Audits the practice had carried out demonstrated how outcomes for patients had been improved. However, there was not a formal programme of clinical audit and we were told these were done on an ad-hoc basis, depending on local priorities and external requests.

The practice collected data for the Quality and Outcomes Framework (QOF) and used this data to monitor performance outcomes. QOF is a voluntary incentive scheme for practices to provide good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. The practice's performance against individual targets were discussed at weekly management meetings. According to the QOF data available to us, the practice performed positively in several areas, including diabetes, dementia and managing patients with high blood-pressure. The practice also benchmarked its performance against other practices in the locality. Locality meetings were held with 11 other GP practices in the area to discuss guidance and data such as, prescribing activity, A&E attendances and referrals.

In August 2013, the practice achieved the Royal College of General Practice's Quality Practice Award (QPA), the highest award attainable. QPA is a standards-based quality accreditation process designed to improve patient care by encouraging and supporting practices to deliver the very highest quality care to their patients. Practices are assessed against a variety of areas, including clinical outcomes and patient experience. The assessment comprises of a written submission and a full day practice assessment by a panel of three. Practices are judged against six modules which examine how the practice ensures it is patient-centred, how it meets the needs of different groups, how it manages illness and how it is a learning organisation.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. The practice had experienced a high turnover of GP and practice managerial staff in the last eight years and the GPs partners were hopeful it had now stabilised.

We reviewed the practice's training matrix which monitored when staff training was due. All staff were required to complete mandatory training in basic life support, information governance, fire safety and infection control. Whilst all GPs had received safeguarding protection training, there was some uncertainty and a lack of evidence to demonstrate that the nurses and administrative staff had received any. This was arranged following our visit. Staff were given the opportunity to attend additional training that was relevant to their roles or as a development opportunity. For example, two members of reception staff were training to become Healthcare Assistants (HCA) and the nurses had attended courses, including diabetes, vaccination updates and independent prescribing training, to enable them to provide specific services to patients.

The practice was a training practice and the two GP partners were GP trainers. We spoke with two medical students during our inspection and they could not be more complimentary about the support and training they had received. One of the practice's salaried GPs had originally trained at the practice and had returned to work there.

All GPs and nurses were up to date with their continuing professional development (CPD). The GPs had either been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

We were told that all staff were required to complete an induction when they first started working at the practice. Whilst we found an induction form in each staff member's file, they had not always been fully completed. The practice manager met with each member of administrative staff on a monthly basis, but these were not documented. The nurses and healthcare assistant told us they had monthly supervision, but these were also not formally documented. We were told that all staff were now due their annual appraisal. One member of the nursing team had been appraised in 2014, but none of the remaining staff had

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Are services effective?

(for example, treatment is effective)

been appraised since April 2013. Staff we spoke with told us they felt fully supported and actively encouraged to develop within their roles. For example, a member of the administrative team had received dementia training and was the practice's Dementia Friend.

Working with colleagues and other services

The practice proactively worked in partnership with a variety of external partners in order to best meet the needs of its patient population and those of the local community. One of the GP partners was a member of the CCG's governing board and took a lead role in a number of projects and initiatives to benefit the local community. For example, he was the CCG's lead for the Staying Healthy Campaign, patient engagement and the lead for the locality.

The practice held weekly clinical meetings and there was a rota in place for relevant professionals to attend on a monthly basis to ensure a co-ordinated, multidisciplinary approach to patient care. These included health visitors, district nurses, the palliative care team and the psychologist attached to the practice. We looked at the minutes for the last three meetings and found them to be brief and it was not always clear who was responsible for taking the required action when individual patients were discussed. Joint meetings were also held at patient's homes or residential homes for patients with complex needs and/ or where best interest decisions were needed.

The practice had achieved and implemented the gold standards framework for end of life care. According to data available, the practice had multidisciplinary case review meetings at least once every three months where all patients on the palliative care register were discussed, which was better than the national average.

During our inspection we spoke with health professionals that worked with the practice, including a health visitor, the district nursing team, the psychologist and two residential homes. All were complimentary about the way they worked with the practice. They described the GPs as responsive, caring and efficient who dealt with patient concerns appropriately.

Blood results, X-ray results and letters from the local hospital including discharge summaries were received electronically. Blood results came into a central email account and were distributed to the GP responsible. There was a system in place to cover annual leave or absences so that no blood results were missed. We were advised that these were all dealt with daily and it was the GPs' responsibility to take any action required. If a patient was seen by the out of hours provider, this was submitted to the practice via email, allocated to the duty GP and filed in the patient's notes. We checked the practice's pathology results mailbox and saw that all results had been actioned.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice was signed up to Co-ordinate My Care (CMC) for palliative care patients, accessible to professionals and care services involved in their care. The practice also alerted the out-of-hours provider to any patients who may be vulnerable or who may require assistance by creating a "special note" on the patient record. The residential home we spoke with told us they had electronic access to their clients' patient records. This allowed them to check any pathology results or to produce a summary of the record if their client was admitted to hospital.

Systems were in place for making referrals, using the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice has also signed up to the electronic Summary Care Record (SCR) (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients could opt out of having a SCR by completing a form.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Three clinicians had attended training on assessing capacity in end of life care.

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Are services effective?

(for example, treatment is effective)

Patients with a learning disability, mental health conditions and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. According to data available, over 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, annually agreed care plan in their record which was significantly higher than the national average of 86%. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. This included working with other relevant professionals and the patient's next of kin. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, parental consent was documented in the patient's notes for childhood immunisations. We were given an example of where the identity of a parent had been verified before the immunisations were administered.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. The practice had also been asked to produce an action plan to demonstrate how it would help meet the priorities of the CCG's Quality Improvement Plan.

All new patients were offered an NHS health check when they registered with the practice and any patients aged over 40 were offered a health check annually. These were carried out by the healthcare assistant (HCA) and any issues were escalated to a GP. If the concerns required urgent attention, the patient was seen by the duty GP. The uptake of these checks for patients aged between 40 and 74 was only 5.4% and the practice was working with the organisation who sent out reminder letters to see if there were ways they could increase it. Eighty two per cent of patients on the practice's mental health register had had a physical health check in the previous year. There was a self-assessment health check machine in the waiting area where patients could check their weight and blood pressure. The readings were added to their medical record by administrative staff. Ninety three per cent of patients over 45 years old had a blood pressure recording in their patient notes within the last five years.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was similar to the CCG average. For example, the uptake rate for children aged 12 months and under was between 79% and 90% for the three standard vaccinations. The results for the 24 month and five year programme were similar.

The practice's performance for cervical smear uptake was 79.4%, which was slightly below the national average of 81%. Those that failed to attend were followed-up by the practice.

The practice provided flu vaccinations for "at risk" patients and their uptake rate was slightly higher than the national average at 55% compared to 52%. Seventy per cent of patients over 65 had received a flu vaccine, which was lower than the national average of 73%. We saw this service was advertised in the waiting area and staff told us they provided opportunistic advice when patients attended the practice.

Lambeth has a higher prevalence of smoking than the London average and was identified as a priority area for the borough. The smoking status of the practice's patients aged over 16 years old was recorded in 83% of cases. In 96% (national, 95%) of patients who were current smokers with a physical and/or mental health conditions had been offered smoking cessation support and treatment within the preceding 12 months. The practice provided weekly COPD clinics to help with smoking cessation. These were led by a GP and a nurse who specialised in COPD. In 2013-14 the practice was in the top 10 of Lambeth practices with over 45% of patients quitting smoking. In the first quarter of 2014-15, the rate had increased to 54% and the practice was in the top five of Lambeth practices.

There was a variety of health information and advice in the waiting area. These did not just relate to health conditions,

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Are services effective?

(for example, treatment is effective)

but signposted patients to organisations and activities going on in the community, such as group walks, reading groups and the garden co-operative. The practice also had access to two Health Trainers on a weekly basis. Their aim was to help people to develop healthier behaviour and lifestyles in their own local communities by offering practical support to change their behaviour to achieve their own choices and goals.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National Patient Survey and a survey of 378 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources indicated that the majority of patients were satisfied with how they were treated.

Eighty six per cent of respondents to the National Patient Survey said they would recommend the practice to others, which was slightly higher than the national average. However, the practice was below the Clinical Commissioning Group (CCG) average in some areas. For example, some patients felt they did not have enough time with their GP, that their GP was not good at listening to them or treating them with care and concern. The practice was above average for its satisfaction scores on consultations with nurses. Eighty per cent of respondents said that the nurse was good at listening to them and 81% said the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and most were positive about the service experienced. Patients said they thought they received quality care from the GPs, nurse and reception staff. They said staff treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said that their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. At reception there was a sign asking patients to wait behind a line so that only one patient at a time approached the desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

We did not observe any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected. Staff were able to describe the practice's patient group, some of whom had complex needs or whose circumstances may make them vulnerable, including patients with mental health conditions, homelessness or victims of domestic abuse. It was the practice's policy to reduce any barriers to them receiving care and staff demonstrated sensitivity when describing how they dealt with different scenarios.

The practice had a chaperone policy. We saw notices in the waiting area and in each consultation room informing patients that chaperones were available. Female patients we spoke with told us male GPs always offered them a chaperone if they were to have an intimate examination. They also told us they could request to see a female GP and this was arranged.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 75% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. 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 they wished to receive. Patient feedback on the comment cards we received was positive and aligned with these views.

The practice aimed to make patients partners in their own care, particularly those experiencing poor mental health, those with long term conditions and those needing

Are services caring?

palliative care. According to data available, 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their patient record and this compared positively to the national average of 86%. In addition, 90% of patients diagnosed with dementia had received a face-to-face review of their care compared to a national average of 83%. The practice had recently begun providing GP services to a residential care home for patients with complex needs and to patients at a specialist residential care home for mental health conditions. The lead GP described the actions taken to ensure patients and their relatives were involved so that care could be provided in their best interests.

The practice was located in an ethnically diverse area where up to 150 languages were spoken. Staff told us that translation services were available for patients who did not have English as a first language. This included a telephone interpretation line, face-to-face interpreters (arranged in advance) and online translation facilities.

Patient/carer support to cope emotionally with care and treatment

The GPs we spoke with told us that if a patient had suffered a bereavement or an upsetting diagnosis, they were telephoned or written to and invited in to the practice for an informal meeting. The patients we spoke to on the day of our inspection and the comment cards indicated that staff responded compassionately when they needed help and provided support when required. They gave examples of GPs offering further support, such as counselling. A psychologist and an alcohol and drugs counsellor attended the practice once a week and patients could access their services via a referral from a GP.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. A member from the Citizens Advice Bureau (CAB) attended the practice two mornings a week and patients could make an appointment for advice. One member of staff had been trained as a “Dementia Friend” whose role it was to meet with carers of patients with dementia to signpost them to support organisations. This was a relatively new role and the practice was considering how best to make relevant patients aware of the service.

The practice had recognised that social isolation was a risk for a number of their patients and it had proactively thought about ways to improve their overall health and well-being. For example, the practice had been the first in Lambeth to create a gardening co-operative where patients could come twice a week and help grow vegetables in the practice’s garden to sell to local health and social care providers. The practice also held a Christmas party each year for their patients who were aged over 80 years old, providing food and a gift for each attendee supported by local charities. We saw photographs of last year’s festivities. These initiatives were advertised in the waiting area and patients we spoke with were aware of them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The individual needs of the practice population were understood and were central to the planning and delivery of services. The practice engaged with other organisations and the local community to ensure it met the needs of its patients. The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. One of the partners was the locality lead for the CCG. In addition, every practice in Lambeth was required to produce an action plan to demonstrate how it would meet the priorities of the CCG's Quality Improvement Programme in order to provide high quality health services. The practice had submitted its action plan in July 2014 and were told performance would be reviewed by the CCG every six months.

The practice was located in an area of high deprivation and we were told this affected approximately 70% of its patients, some of whom were vulnerable. These included patients who were socially isolated, those suffering from substance misuse, mental health conditions and homelessness. The practice provided GP services to two residential homes for patients with complex needs, including a specialist home for patients with mental health conditions. We spoke with the two residential homes and their clients received good continuity of care as it was usually the same GP who attended. The GP visited the homes for a weekly clinic, they told us he also provided advice over the telephone or carried out additional visits if required.

A drugs and alcohol worker and a psychologist held weekly clinics at the practice for patients referred by their GP. The practice also worked with a number of voluntary organisations and hosted events, recognising the need to support patients' emotional well-being as well as their health needs. There were several examples of where the practice had demonstrated innovation; it had been the first practice in Lambeth to have a reading group and the first to have a gardening co-operative. More recently the practice had got involved with an organisation that specialised in promoting and supporting mental well-being through creativity.

There were innovative approaches to providing integrated person-centred pathways of care. Approximately 63% of patients had a long-standing health condition and the practice had clinical leads for a variety of conditions, including diabetes, asthma and chronic obstructive pulmonary disease (COPD). All patients with long term conditions were invited for annual reviews and medication reviews. Diabetes had been identified as a priority area for the CCG. Weekly, nurse-led clinics were held with input from the lead GP and community specialists. For example, the nurse practitioner held virtual clinics with the community diabetic specialist nurse and a hospital consultant during patient consultations for those with complex needs. Virtual clinics were also held to get specialist input for complex COPD patients. We spoke with two patients with diabetes. They were complimentary about the care they received and felt they had been well supported to manage their condition.

The practice held weekly COPD clinics to help with smoking cessation, weekly well woman clinics and weekly baby clinics, during which time appointments could also be made with the health visitor.

The practice had a patient participation group (PPG) which consisted of 120 members. The practice was in the process of finding a patient who could chair the group and told us it was currently not self-managing. This supported the views of the two PPG members we spoke with who were complimentary about the open culture, but stated the meetings were an opportunity for the practice to deliver messages rather than actively involving patients. However, the practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and from patients. For example, in response to the practice's March 2014 survey where 26% of respondents had an occasion when they could not book an appointment, the practice had implemented a daily walk-in clinic. They had also begun to produce information leaflets in large font and to identify those who may require large font communication from the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Tackling inequity and promoting equality

One of the GP partners was the CCG's patient engagement lead and had a key role in a project looking to reduce health inequalities in Lambeth. Staff we spoke with were committed to providing an accessible, welcoming service to all. There was no limit placed on the number of patients that could register and they were not required to provide proof of address in order to do so. We were also given examples of where potentially challenging patients had been registered with the practice despite living outside of the catchment area.

Approximately 150 different languages were spoke in Lambeth. The majority of the practice's patient population spoke English though it could cater for other different languages through telephone, online and face to face translation services.

The practice was accessible to patients with disabilities and those with pushchairs. The practice was situated over the ground floor and there was sufficient space within the waiting area, consultation rooms and corridors to manoeuvre a wheelchair. Some patients we spoke with commented that the front door was heavy and difficult to open as it was not electronically operated, especially for wheelchair users. The practice management were aware of the concerns and were in negotiation with the owner of the building to find a solution.

Access to the service

The surgery was open from 08.00 to 18.30. Appointments were available from 08:30 am to 18:30 pm on weekdays. In addition, the practice offered extended opening hours from 7:00am to 8:00am on Monday and Wednesday mornings when two GPs predominantly saw patients of working age. Patients could book appointments over the telephone, online or in person. At the time of our inspection, the practice did not send patients texts to remind them of their appointment. The practice had tried to deliver a telephone triage service but this had not addressed either patient or doctor needs. As a result the practice offered a daily morning walk-in service for both routine and emergency appointments where patients would be guaranteed to be seen "on the day" if they arrived before 10:30am. The practice also offered telephone consultations. The practice closed occasionally for protected learning time for staff and all calls were transferred to the practice's out-of-hours provider. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the practice's information leaflet.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. It also outlined what treatments and procedures the practice's nurses could carry out so patients did not always have to see a GP.

According to the National Patient Survey, the practice was amongst the best in the CCG for the proportion of patients who found it easy to get through to the practice on the telephone (91%), were satisfied with the practice's opening hours (88%) and were able to get an appointment the last time they tried (93%). Most patients described their experience of booking an appointment as "good". Patients we spoke with during our inspection and the comment cards we received mirrored these findings. They felt that there were both positives and negatives to the walk-in service; they could be seen when they needed, but they may have to wait for over an hour. Despite this, they felt it was an improvement and knew they could book an appointment if they preferred.

Appointments were usually 10 minutes in length, but 20 minute slots were available if required. Annual reviews were usually 30 minutes. The practice's electronic records system alerted staff if they were classified as vulnerable or had a long term condition so the length of appointment could be tailored to meet their needs. We were told that any children under one years of age or the elderly were seen as a priority during the walk-in clinic. If reception staff were particularly concerned about the well-being of a patient in the waiting room they were able to send instant alerts to the GPs or activate their panic alarm.

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. Information on how to

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

make a complaint could be found in the waiting area, the practice's information leaflet and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice manager told us they logged any comments or concerns to ensure any issues were captured, including those that were informal. We looked at 27 verbal or written comments or complaints received in the last 12 months and found they were centrally logged, investigated and responded to in a timely way in accordance with the practice's policy. We saw that where appropriate, the practice had apologised to the patient and explained the action taken.

As a result of several comments and complaints received about the process for repeat prescriptions, the practice held a meeting in October 2014 for patients which was attended by 55 patients and the GP partners. The issues with the current system were discussed and proposed actions were agreed. For example, an information leaflet for patients was produced, information screens for the reception area had been ordered and two reception staff were receiving specific training on the taking repeat prescriptions.

We saw that complaints were discussed at management and clinical meetings. However, as administrative staff meetings were held informally and not minuted we could not be assured that learning from complaints was cascaded effectively. Staff we spoke with told us they were made aware of any learning and changes to practice policy

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's mission statement was publicly available on the practice's website and public areas. The practice vision and values included the following aims; to provide high quality healthcare; to strive for excellence; develop and improve through teaching, training, research and listening to patients; to create a friendly and cohesive work environment; to invest in development of the practice in order to meet the needs of the community.

Staff we spoke with were aware of the practice's mission statement and shared the same values. They displayed pride in their work and some had worked for the practice for many years.

Governance arrangements

Since the current partnership was formed in 2006, the practice had had a high turnover of both practice managers and GPs, which had impacted on some systems and processes. The current practice manager had been in post for just over a year and it was clear they were making steps to address some of the process gaps. It was acknowledged by senior management that there were still some important areas that remained to be addressed and these included areas such as following recruitment procedures and general record keeping of meetings and agreed actions. There was a written leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. Most lead areas were assigned to the two GP partners and the practice manager; very little was delegated to the other GPs.

The practice had a number of policies and procedures in place relating to the day to day running of the service. These were available to staff on a shared drive on any computer within the practice. We looked at six of these policies and procedures and saw they had been reviewed and updated in October or November 2014.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance, as well as data from the Clinical Commissioning Group. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at weekly management meetings with agreed actions documented to improve outcomes.

One of the GP partners told us the practice did not have a rolling programme of clinical audit. Whilst at least two audits had been completed, these were normally based on those required for QOF purposes or the CCG and there was no strategic plan as to how the practice intended to include completed audits as part of its process to continually improve quality.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us logs that were kept in relation to incidents, complaints and performance targets. These were discussed at weekly management and clinical meetings. Risk assessments had been carried out where risks were identified, such as the risk of fire and legionella. Where appropriate, action had been taken to mitigate against these risks.

The practice held weekly management and clinical meetings and we looked at minutes from the last three meetings from each. The management meetings discussed performance against a variety of targets and responsibilities and actions were recorded. However, we found the notes from the clinical meetings were brief and it was not always clear who was responsible for taking the required action.

Leadership, openness and transparency

We saw from minutes that the management team and clinical team, including the nurses and healthcare assistant team, both met weekly. There was a rota in place so that different groups, such as administrative staff and other health professionals attended clinical meetings periodically. We were told that the practice manager met with administrative staff formally each month, but these meetings were not minuted. All staff we spoke with described an open, friendly, "no blame" culture and told us they felt comfortable raising any concerns. The management team told us they had an "open door" policy and encouraged a non-hierarchical structure, which was supported by the view of other staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments via its website and complaints

Are services well-led?

Good

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

received. In response to feedback from patients, the practice had changed its appointment system to provide a daily walk-in clinic so that patients could be seen the same day. The practice had also responded to comments received about the process for obtaining repeat prescriptions by holding a meeting in October 2014 with patients to answer questions and to look at possible improvements.

The practice had a patient participation group (PPG).This was currently being managed by the practice who had requested members to register their interest to chair it. The fact that the PPG is led by the practice and not by patient representatives reflects the feedback we received from some PPG members we spoke with. They told us that whilst they appreciated the meetings, they were not given an agenda in advance and it was more of an opportunity for the practice to share messages rather than it being fully participatory. The PPG's membership had steadily increased in size to 120 members and we saw from meeting minutes that attendees to meetings often exceeded 50. The practice told us that the group was gradually becoming more reflective of the patient population due to sending invitations to meetings via text message. The results, analysis and action plan from the March 2014 feedback survey were discussed with the PPG. The minutes of all the PPG meetings were available on the practice website and in the practice's waiting room. They were also available in large font for those with a visual impairment.

The practice had gathered feedback from staff through a staff survey, staff away days and generally through staff meetings, appraisals and informal discussions. We looked at the results of the 2014 staff survey which was discussed at a team away day in May. The results indicated that most staff were satisfied with the opportunities to develop professionally and the training provided by the practice. They also showed that staff felt motivated by their job and thought the team was respectful and supportive of each other. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management; they felt involved and engaged in the practice to improve outcomes for both staff and patients.

There were a variety of policies and procedures in place to support staff, including a whistle-blowing policy, and all staff we spoke with knew where to find them.

Management lead through learning and improvement

In August 2013, the practice achieved the Royal College of General Practice's Quality Practice Award (QPA), the highest award attainable. QPA is a standards-based quality accreditation process designed to improve patient care by encouraging and supporting practices to deliver the very highest quality care to their patients. It involves the participation all practice staff and thus recognises the team's commitment to reflection, learning and improving in order to provide quality care. Practices are assessed against a variety of areas, including clinical outcomes and patient experience. The assessment comprises of a written submission and a full day practice assessment by a panel of three. Practices are judged against six modules which examine how the practice ensures it is patient-centred, how it meets the needs of different groups, how it manages illness and how it is a learning organisation.

Staff demonstrated a commitment to continually learn and improve. However, there were some areas where the current systems and process prevented this from happening. For example, whilst staff reported incidents internally and externally, the analysis and learning from this was not always thoroughly documented or formally disseminated to all staff.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The GPs had received their annual appraisal. However, some of the remaining clinical staff and administrative staff had not been appraised in over a year and previous appraisal documentation was incomplete.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider must take steps to ensure patients and staff are sufficiently protected from the risk of infection by the effective operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections. Regulation 12 (1) and (2) (a).**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider must ensure patients are fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up a post. (Regulation 21 (a) and (b)).**