Care Quality Commission

Addiscombe Road Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Addiscombe Road Surgery on 07 October 2014. The provider, Dr Bellanage Sunanda Jayaratne, has a branch surgery to Addiscombe Road Surgery, 139 Northway Road Surgery, which is also in Croydon. We did not visit the branch surgery as part of this inspection.

We found that overall Addiscombe Road Surgery was rated as requires improvement. We found them Good in the Caring, Responsive and Well Led domains, but there were areas of the Safety and Effectiveness domains that required improvement.

Our key findings were as follows:

- The practice referenced published best practice guidelines and the local clinical commissioning group guidelines in ensuring positive health outcomes for patients.
- The practice used the Quality and Outcomes framework to measure, monitor and improve performance. The practice was performing well against most indicators compared to other practices in the area and against national averages.
- The practice was well-led and its predominantly long serving staff team felt valued and supported. The staff team displayed a real sense of pride in the work they did.
- The practice had an active patient participation group, members of which praised the support they had received from the practice team and how well the practice responded to their suggestions
- Patients consistently reported good experiences of the care and treatment they had in the practice, and felt the entire staff team contributed in one way or another to their care.

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

Importantly, the provider must:

Summary of findings

- Ensure the recruitment policy is followed fully in the recruitment of new staff

In addition, the provider should:

- Ensure clinical audit cycles are completed to determine if improvements had been maintained
- Ensure full job descriptions are in place for all members of the staff team, so that staff are clear about their role and responsibilities.
- Ensure records of the checks of the oxygen cylinder are maintained
- Ensure it takes active steps to increase its flu vaccinations uptake in order to meet set targets.
- Ensure formal training is provided to the practice's safeguarding lead to support them in performing that role
- Ensure the practice vision and values are shared from the leadership team with the practice staff team and patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for safe. We saw evidence of suitable systems and arrangements in place to protect people from harm, and that staff were able to understand fulfil their roles and implement them. This included medicines management and infection control. However we found that there were certain aspects of the safety arrangements that need to be improved. The practice's recruitment procedures had not been properly followed for the most recent employee in the practice. The practice needs to ensure records of the checks of the oxygen cylinder are maintained. The practice also needs to ensure the safeguarding lead in the practice completes level three training in safeguarding and child protection.

Requires improvement

Are services effective?

The practice is rated as requires improvement for effective. The practice employed a multi-disciplinary approach to ensure care and treatment was appropriate and met people's needs. The practice had good communication channels and strong working relationships with other agencies involved in people's care, such as the district nursing, palliative care and social services. The practice kept up to date with and implemented the latest published guidance for clinical practice and its clinical commissioning group (CCG) protocols for care pathways.

The practice monitored its performance in delivering agreed clinical outcomes for its patient population through the Quality and Outcomes framework (QOF), and its performance was similar to other practices in the local areas, and in the mid-range compared with national performance in most areas. We noted the practice performed particularly well against emergency cancer admissions for patients on the disease register; the percentage of patients with diabetes with a record of a foot examination and risk classification within the preceding 15 months; the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months; and patients diagnosed with dementia whose care has been reviewed in the previous 15 months. However, improvements were needed in its flu vaccinations performance. We found that the practice was performing below the national average across all risk groups for the percentage of patients who have received a seasonal flu vaccination.

Requires improvement

Summary of findings

The practice carried out a range of clinical and general audits. However we found that there were some second cycles required to be completed for clinical audits.

Are services caring?

Good

The practice is rated as good for caring. We received consistently and strongly positive feedback and praise from patients and members of the patient participation group about the staff team and the care and treatment they provided. Throughout our own observations during our inspection of the atmosphere in the practice, and staff and patient interactions, we found the practice team to be passionate about delivering patient centred care. The staff team were open, welcoming and caring towards their patients. The staff team were long established in the practice and knew the patients well. Staff welcomed patients and responded to their queries with warmth and courtesy.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was accessible and adaptable to the needs of its patients. Appointments could be made to see the doctor or nurse by phone and in person at the practice. Longer appointments were provided for patients with more complex needs or where they were deemed necessary such as for review and for antenatal appointments or baby checks.

The practice understood the needs of its patients and there were provisions made to meet people's specific needs, such as those who attended emergency services regularly, or people with mental health needs or learning disabilities.

The practice responded to comments and complaints from its patients and others to improve the service.

Are services well-led?

Good

The practice is rated as good for being well led. The staff in the practice were supported to learn and develop in their roles, and they worked well as a team. Staff had a sense of pride, commitment and professionalism in the work they do.

The management team was present, open and approachable. We found that more formalising and promoting of the practice vision and values were required, and in some aspects of the service there could be more clarity about roles and responsibilities.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. The practice had a higher proportion of patients aged 65 and over, than the local average. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care and worked collaboratively with other services to meet the needs of the older people in its population. The practice delivered a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits, longer appointments and rapid access appointments for those with enhanced needs.

However we found that the practice was performing below the national average for the percentage of patients aged 65 and older who have received a seasonal flu vaccination.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the clinical team worked with relevant health and care professionals to deliver a multidisciplinary package of care. However, we found that the practice was performing below the national average for the percentage of patients aged over 6 months to under 65 years in the defined influenza clinical risk groups that received the seasonal influenza vaccination.

Families, children and young people

Good

The practice is rated as good for care of families, children and young people. Systems were in place for identifying and following-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. Immunisation rates were relatively high for all standard childhood immunisations; the practice had 93.3% to 96.7% of children up to the age of 12 months receiving the recommended vaccinations, whilst the average for the local area was 88.5% to

89.4%. All of their patients at 24 months had received all their recommended vaccinations, with the exception of the combined measles mumps rubella (MMR) vaccine which 90.5% of patients had received (the average for the local area for MMR was 87.5%).

Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of the 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. The practice was proactive in offering later appointments on certain days. A full range of health promotion materials was made available in the practice waiting area, on their website and through their patient leaflets. Screening programmes, such as well man and well woman health checks were available to patients. There were no online services, such as appointments booking and ordering of repeat prescriptions, available at the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with no fixed abode, and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia) The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of these patients. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.	**Good**

Summary of findings

What people who use the service say

We spoke with nine patients and two members of the patient participation group during our inspection. We received consistent and strongly positive feedback and praise from them about the staff team and the care and treatment they provided. Patients we spoke with said they felt safe in the care they received from doctors and the nurse. Patients told us they were treated well by all the staff when they accessed the practice. Patients told us they felt involved in, and supported to make decisions about their care.

Patients told us they were treated with dignity and respect and that their privacy was maintained.

Comment cards were provided before the inspection for patients to complete. We received completed comments cards from 24 patients. Their feedback was also consistently positive and aligned with the views of patients we spoke with on the day.

The national GP patient survey results found the practice was performing above the national averages for positive overall experiences of their GP, the GP and nurse were good or very good at involving them in decisions about their care, and the GP and nurse were good or very good at treating them with care and concern.

The practice also carried out its own annual patient survey and the results of the latest survey aligned with these views.

Areas for improvement

Action the service MUST take to improve

The practice must ensure the recruitment policy is followed fully in the recruitment of new staff

Action the service SHOULD take to improve

- Ensure clinical audit cycles are completed to determine if improvements had been maintained
- Ensure full job descriptions are in place for all members of the staff team, so that staff are clear about their role and responsibilities.
- Ensure records of the checks of the oxygen cylinder are maintained
- Ensure it takes active steps to increase its flu vaccinations uptake in order to meet set targets.
- Ensure formal training is provided to the practice's safeguarding lead to support them in performing that role
- Ensure the practice vision and values are shared from the leadership team with the practice staff team and patients.

Care Quality Commission

Addiscombe Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP and an expert by experience.

The GP and expert by experience were granted the same authority to enter the practice as the CQC inspector.

Background to Addiscombe Road Surgery

Addiscombe Road Surgery is a single handed practice provided by Dr Bellanage Sunanda Jayaratne. The practice is located in Addiscombe, within the London Borough of Croydon. The practice had 2984 patients at the time of our inspection and had been operating under the current provider for 22 years. The practice provided regulated activities from its main site at Addiscombe road, and from its branch surgery at 139 Northway Road, Croydon.

Addiscombe Road Surgery is registered to carry on the regulated activities of Diagnostic and screening procedures, Family planning services, Maternity and midwifery services, Treatment of disease, disorder or injury to everyone in the population.

Care, treatment and support was provided by one full time male doctor and two regular female locum doctors, one part time practice nurse, a practice manager, and a team of five reception and administrative staff. The locum doctors worked for one and two sessions respectively, and the practice nurse worked for 26 hours a week.

The patient population at the practice was stable and made up of 70% older people (over 65 years of age). The average proportion of patients over the age of 65 registered in GP practices across England is 26%.

The practice operated under a General Medical Services (GMS) contract from NHS England for delivering primary care services to its local community.

The practice had opted out of providing out-of-hours services to their patients.

Why we carried out this inspection

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

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

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

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, NHS England and the practice's clinical commissioning group (CCG), to share what they knew about the practice.

We carried out an announced visit on 07 October 2014. During our visit we spoke with a range of staff (doctor, nurse, practice manager, reception and administrative staff) and spoke with patients who used the service. We observed staff interactions with patients and talked with carers and/or family members.

We reviewed documentation relating to the operation of the practice such as policies and procedures, staff records and certification to verify the health and safety of the premises. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. Information used included reported incidents, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed during the last 12 months. We found that the practice had managed these consistently over time and so could evidence a safe track record over the long term.

An accident book was maintained by the staff team, and four incidents had been recorded during 2014. In each case the incident was responded to and any necessary actions taken.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events.

Records were kept of significant events that had occurred during the last 12 months and these were made available to us.

We reviewed 3 significant events analyses that had been completed in the practice. We found that they all showed clear record of the events that had occurred, the subsequent actions taken and the lessons learned.

A slot for significant events was on the practice meeting agenda so there was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw an incidents folder was maintained in the practice. We tracked the four incidents that had been recorded during 2014 and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example skylight maintenance was carried out to eliminate the risk of injury in the reception area.

National patient safety alerts were disseminated by the practice manager to practice staff, verbally, by email and through practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. The GP in the practice had completed level three training in child protection and training in safeguarding adults.

The staff in the practice demonstrated an understanding of which might constitute abuse, and when people may be in vulnerable circumstances. The nurse, who was also the safeguarding lead, was able to give us an example of a safeguarding case, which they had appropriately responded to, and alerted the correct parties about. However we found that there were no records indicating that the nurse had completed formal training in child protection to support them in performing the safeguarding lead role.

The doctor also showed a good working knowledge and understanding of safeguarding matters. He told us that the practice looked after a children's home, which mainly accommodated teenagers, taken into care as a result of parents' problems.

Both the doctor and the nurse told us they provided information as requested for safeguarding case conferences.

The administrative team had completed safeguarding awareness training.

All members of staff in the practice had Disclosure and Barring Service (DBS) checks completed for them, with the exception of the most recent recruit, a new member of administrative support team. The practice manager told us they intended to carry out a DBS check for this new member of staff in the very near future.

A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken by the practice nurse. If the nurse was not available to act as a chaperone, two receptionists had also

Are services safe?

undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. All members of staff acting as chaperones had completed DBS checks.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers) had notes against their records which indicated their vulnerability. They were followed up and discussed as part of multi-disciplinary meetings.

The practice used a risk stratification tool to identify patients with high numbers of emergency department attendances. These patients were invited in to see the doctor for a review and a plan of care was developed with them. There was follow up of children who persistently failed to attend appointments, such as for childhood immunisations. Data showed that the practice performed better than the CCG average for all childhood immunisations.

There was a system in place for reviewing repeat prescription medicines for patients with co-morbidities and / or multiple medicines. The GP and practice manager told us that these patients were invited for regular reviews, six monthly or sometimes more frequently if there was that need.

The practice management arranged for an annual health and safety review to be completed in the practice. This covered risk assessment and hazards reporting, occupational health and health surveillance and fire and emergency arrangements. This review verified that the appropriate health and safety precautions were in place. For example, clear and visible emergency exit and fire extinguisher signage was in place throughout the premises. Water and carbon dioxide extinguishers were available and were in date for servicing.

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. There was a clear policy for ensuring medicines were kept at the required temperatures, and the action to take in the event of a potential failure was described. This was implemented by the practice nurse who had overall responsibility for management of medicines, including vaccines.

Vaccines were administered by the nurse using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of the directions and evidence that the nurse had received appropriate training to administer vaccines.

The nurse told us the majority of vaccines arrived on Mondays which was one of her workings days. If the nurse was not available, they alerted the reception staff in how they must store the medicines.

The medicines fridge temperature was checked every morning, and this was confirmed by maintained records. On the day the practice nurse did not work, a specific member of the reception staff team carried out the fridge temperature check. There was a protocol in place to follow if the fridge temperature went out of range, which included contacting the medicines manufacturer for guidance, or discarding medicines that were deemed no longer safe to use.

We inspected the contents of the medicines fridge. The fridge was well stocked and not overfilled. We checked a sample of the medicines and found them to be in date and intact.

There were no controlled drugs kept in the practice.

The practice aimed to issue repeat prescriptions with 48hours of the request being made. The staff told us they often issued the prescription immediately if they had the time to do so.

The GP told us that he carried out a six monthly review, attended by the patient in person, for all patients on repeat prescriptions. The administrative staff put a sticker on the back of patients' prescription asking them to make an appointment to see the doctor before their next prescription was due.

Requires improvement

Are services safe?

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control in the practice, and had recently completed update infection prevention and control training.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, 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 in order to comply with the practice's infection control policy.

The practice had received a recent infection prevention and control inspection from the NHS England local area team. We saw evidence that the practice was making improvements in response to the findings. This included the ordering of new flooring for the treatment room, new labelling for clinical waste, and legionella testing was being arranged.

Staff knew the appropriate actions to take in response to needle stick injuries. There was a written policy for needle-stick posted on treatment room door.

Equipment

The GP and nurse told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

A spirometer was in place in the practice, which the nurse used in the treatment of patients with asthma and chronic obstructive pulmonary disease (COPD).

An oxygen cylinder was also available in the practice, and stored in the GP's room. We found this was in date for use, and was due for service in June 2015.The bag containing the oxygen cylinder also held masks for adult and children.

Blood pressure (BP) monitors were inspected and calibrated annually by a contracted external company. We inspected the BP monitor in the treatment room and found it to have been recently checked, on 22 September 2014.

Portable appliance testing (PAT) was completed for the electrical equipment in the practice in September 2014.

Staffing & Recruitment

The practice had a recruitment policy and procedure that set out the standards it followed when recruiting clinical and non-clinical staff. The policy and procedure took account of the completion of appropriate background checks for new staff, verification of previous employment, skills and qualifications.

An induction process was also in place for new staff, which included reading and a discussion of the practice policies and procedures, a health and safety induction encompassing a display screen equipment assessment, and an explanation of the new staff members' duties.

One new staff member had been employed within the last 12 months preceding our inspection. The remaining members of the staff team had been in employment for many years in the practice. We found that employment contracts were in place for all members of the staff team. For the newest staff member, who was a member of the administrative team, a disclosure and barring service check had not been completed for them, and no references had been obtained for them.

Staff records we looked at showed that staff members had received documented terms of employment, which set out their conditions of employment and included sections such as sickness and injury payment, health and safety, welfare, whistleblowing, anti-bribery, and capability procedures. Employees also received a copy of the employee handbook.

A brief job description was in place for the practice nurse, but was not detailed and did not describe their tasks and responsibilities in detail. There were no job descriptions in place for the rest of the staff team.

Monitoring Safety & 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. The practice also had a health and safety policy.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies.

We saw records showing that the staff team in the practice received annual training in dealing with medical emergencies, in the form of Cardiopulmonary resuscitation (CPR) and anaphylaxis training. The most recent training session had been completed in March 2014. The training was held within the practice and staff were able to practice and rehearse for scenarios they may encounter in their work setting.

There was an emergency drug cupboard in the treatment room, which was well stocked. All medicines were in date. A records book was maintained of monthly checks of the emergency drugs completed by the practice nurse. We reviewed the emergency drugs records book and found that the checks were last completed in September 2014.

An oxygen cylinder was also available in the practice, stored in the GP's room and was fit for use. The nurse told us that she checked this when she carried out the checks on the emergency medicines, but we found that there were no records maintained to support this.

The practice used ampules of epinephrine for the treatment of life-threatening anaphylactic reactions. The correct doses to be administered were posted in the treatment room on a noticeboard and on the inside of the front door of the emergency drug cupboard.

Requires improvement

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 treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GP and nurse that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GP told us they were the lead on the management of specialist clinical areas such as cancers, dementia and learning disabilities. The practice nurse was the lead for long term conditions such as asthma and hypertension. The nurse told us that they sought and received input and support from the GP in managing any complex cases. The nurse carried out phlebotomy services in the practice and the GP recalled patients where necessary to discuss their blood results. Patients told us they found this service convenient as they did not need to go to hospital to have such test done.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with used national standards and their clinical commissioning group (CCG) guidelines for the referral of conditions. We saw from the most recent data that the practice was performing particularly well on emergency cancer admissions per 100 patients on the disease register, which was significantly lower than the national average, 0.003 compared with 0.113.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP 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.

Patients with long-term conditions were managed through normal surgery consultations. The practice nurse was the lead for the management of long term conditions. The nurse performed spirometry tests to diagnose and monitor COPD. Where necessary the nurse made referrals for more specialist care and treatment. For example, patients requiring insulin conversion were referred to the hospital diabetic service.

The practice maintained a register of patients with learning disabilities and the GP was the lead person who cared for them. All these patients had received annual health checks. All patients in the practice listed as housebound were also provided annual reviews as well as six monthly medication reviews.

Management, monitoring and improving outcomes for people

The nurse was the lead for chronic disease management in the practice, and led audits in the management of different conditions to monitor patient care and to encourage improvement.

The practice had a system in place for conducting clinical audit cycles. The practice manager told us their clinical audits were often CCG initiated or triggered and linked to their Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool.

The practice showed us two clinical audits that had been carried out during February 2013. The first was a Vitamin D audit and the second a dressings audit. The Vitamin D audit demonstrated that the practice had completed assessments for appropriate patients meeting the CCG guidelines for vitamin D assessment.

The dressings audit showed that the practice was using some expensive dressings that were not on the CCG formulary. As a result, the practice reverted to formulary only and worked with their district nursing teams to align practice. The practice receptionists also stopped printing any dressing prescriptions that were for non-formulary dressings.

We found that both audits did not have completed cycles, as the second cycles of the audits to check that improvements had been maintained had not been carried out.

The service used a clinical commissioning software for risk stratification. The software provided a list of patients at risk

Requires improvement

Are services effective?

(for example, treatment is effective)

and where additional input was required in the management of their condition. For example during September 2014, the system identified five patients that had been frequent hospital emergency department attendees. They were invited for appointments with the doctor to develop a plan of care for them to prevent unnecessary hospital attendances. This was in line with the CCG identified direct enhanced service (DES) of unplanned admissions.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice was part of a cluster of 8 practices that met monthly to discuss practice performance in different areas including prescribing, protocols, emergency department attendances, and referral rates.

The practice found their clinical performance to be in the mid-range across most services, whilst they had particularly good results for their performance in the care of orthopaedic patients. They linked this higher performance in the orthopaedics area to their higher population of older people, so higher levels of referrals and monitoring for cases such as fractured hips and osteoarthritis.

Immunisation rates were relatively high for all standard childhood immunisations; the practice had 93.3% to 96.7% of children up to the age of 12 months receiving the recommended vaccinations, whilst the average for the local area was 88.5% to 89.4%. All of their patients at 24 months had received all their recommended vaccinations; with the exception of the combined measles mumps rubella (MMR) vaccine which 90.5% of patients had received (the average for the local area for MMR was 87.5%).

The practice GP recognised that there was a level of reservation among its patients to flu vaccination. 58.9% of their patients aged 65 and older had received a seasonal flu vaccination, compared to national average of 73.2%. They told us this was a legacy problem from their experience a few years ago when patients experienced side effects when seasonal flu vaccinations were given at the same time as bird flu vaccinations. They told us they were exploring ways of increasing uptake, including discussing and raising the matter through their PPG.

The GP carried out flu vaccinations for patients who were housebound.

A number of regular clinics were held in the practice for specific groups of patients including mother and baby, antenatal, diabetes, asthma and COPD, and hypertension.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Staff received training for their roles and as part of their induction when they joined the practice.

The nurse had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. The nurse had completed diploma level training in relevant courses including asthma, COPD, public health, and diabetes. She told us she completed a minimum of 5 days clinical training every 3 years.

The GP was up to date with their yearly continuing professional development requirements and had a date for revalidation. Their revalidation was due in February 2015. (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).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. All staff were eligible to apply for assistance with training courses or programmes of study.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a process outlining the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP saw all hospital letters, emergency department and out of hours service attendances.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, such as those

with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Although the practice did not have regular mental health meetings, they had access to telephone support from a psychiatrist and were able to get same day referrals for people experiencing mental health problems. The practice could also signpost people to the Improving Access to Psychological Therapies (IAPT) service, which patients could self-refer to for suffering from depression or anxiety disorders.

Patients were referred to relevant support groups and third sector organisations by the practice staff team.

Patients were able to self-refer to substance misuse rehabilitation services and other organisations that provided support for them.

Antenatal checks for pregnant women were shared between the practice and the local hospital. The practice also carried out post natal checks for new mothers, and the baby's six week check.

Information Sharing

The practice used the electronic Choose and Book system for making referrals. The system enabled patients to choose which hospital they wished to be treated in and book their own outpatients appointment in discussion with their chosen hospital. The practice also used a shared system to share information with other health providers including the local out of hours provider.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 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.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

The doctor and nurse demonstrated full understanding of scenarios where consent to treatment would be required. For example the nurse told us about insisting on parental consent being given for children attending for immunisations. Where children were brought in by someone else, such as their nanny or grandparent, they told us they would call a parent to get their consent.

There was a practice policy for documenting consent for specific interventions. The nurse talked us through their process for obtaining and recording consent prior to giving immunisations. They recorded that consent was obtained against the patient record, as was the immunisation batch number, expiry date, site administered, and patient advice given on what to expect following immunisation.

Health Promotion and Prevention of ill health

The practice provided new patient checks for all patients. These checks were routinely carried out by the nurse. However the GP saw patients on medication or with a significant medical problems, concerns or issues.

The practice offered well woman and well man clinics. These provided general health checks for people and offered healthy lifestyle advice to support people who were in good general health to remain healthy.

Information about a range of health promotion initiatives delivered in the practice was displayed in the patient waiting areas. These included the flu vaccination programme for different vulnerable groups of people, smoking cessation, and the shingles clinic. Patients requiring further information and those wishing to book an appointment were able to do so through the administrative team.

The practice leaflet included information about health promotion initiatives, the various clinics available in the practice, and how patients could manage minor ailments at home.

Are services effective?

(for example, treatment is effective)

There was also a new borough scheme available for obese children, which involved the whole family and included cookery classes.

The practice maintained a register kept of patients who were identified as being at high risk of admission and / or who were at the end of life. These patients had up to date care plans developed with them or with people close to them. This information was shared with other providers through multidisciplinary meetings to plan their care.

There was evidence that multidisciplinary case management meetings were held in the practice to discuss the needs of people with high and complex needs.

The practice recognised that they needed to make improvements to their performance in seasonal flu immunisations. 58.9% of their patients aged 65 and older had received a seasonal flu vaccination. The national average was 73.2% of patients aged 65 and older in the winter of 2013 / 14, and the European Union target is 75%.

There was a named GP assigned for patients with high risk or complex needs, including those over the age of 75 and those with long term conditions.

The practice arranged structured annual reviews for patients with long term conditions, including those with Diabetes, COPD and heart failure. 98.9% of the practice patients with diabetes had a record of a foot examination and risk classification within the preceding 15 months. This performance was significantly above the national average is 90.4%.

The practice clinical team used some time during consultations to provide opportunistic health promotion lifestyle advice, and a record of the discussions were included in the patient notes. Where appropriate, the practice nurse made referrals for exercise classes.

There was functionality in the patient records system for the risk stratifying of patients and identifying those at high risk of developing long term conditions.

The practice demonstrated good performance in child immunisations, achieving 90.5% to 100% immunisation rates for all standard immunisations. The CCG average is 73.7% to 93.9%.

There was evidence that the practice signposted young people towards sexual health and smoking cessation clinics. Contraception advice and Chlamydia testing was offered in the practice.

There was multidisciplinary working and sharing of care with other providers for expectant mothers.

The practice held a register of those in various vulnerable groups, including people of no fixed abode, learning disabilities, people in need of end of life care and support. There was evidence of multidisciplinary working in case management of vulnerable groups, and signposting patients to various support groups and third sector organisations.

96.2% of the practice's patients with physical and / or mental health conditions had received an offer of support and treatment within the preceding 15 months. The national average was 93.4%.

All patients with schizophrenia, bipolar affective disorder and other psychoses had a record of alcohol consumption in the preceding 15 months. The national average is 90.9%. There was evidence of multidisciplinary working and case management of patients with mental health problems. The practice also signposted patients to relevant support groups and third sector organisations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and a survey of 20 patients undertaken by the practice in September 2013. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

We observed that patients that came to the practice for their appointments were greeted by the reception staff in a friendly, welcoming and cordial manner. Patients told us they had been at the practice for many years and found the reception staff to be helpful and that they made them feel at ease. They told us they were treated with dignity and respect, and that their privacy was maintained.

When the doctor or nurse was available to see their next patient, they came to the waiting area to greet them and invite them into the consultation rooms.

There was a notice in the waiting area letting patients know that face to face interpreters could be arranged for them if English was not their first language.

The practice was signed up to the local enhanced service (LES) of 2% of its patient population having a named GP and a care plan in place. We found that 97.3% of patients on the register had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. (The national average is 87.4%)

Care planning and involvement in decisions about care and treatment

The national GP 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 90% of respondents said, in reference to their last appointment, that the GP was good at listening to them and 83% said they were good at good at explaining tests and treatments. 71% said the GP was good at involving them in decisions about their care.

Patients we spoke to on the day of our inspection told us they felt safe in the care they received from the doctors and nurse at the practice. All the patients told us they were treated well by al the staff in the practice. Patients told us they felt supported to make informed decisions about their care, and that test results and diagnosis were properly explained to them. Patients gave us examples of where they were referred to a hospital of their choice, and that their preference was taken into account when referring them for specialist services.

All the patients told us their experiences of the practice were positive. They gave many examples of specific experiences of care and treatment that had been individualised for their particular circumstances and had met their health needs or that of their family members.

Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

There were notices and leaflets displayed in the patient waiting area about a variety of support services available to patients. These included bereavement support services, psychology and counselling services, healthy lifestyles advice, advice about choosing a care home, and health promotional services. There was a specific ‘carers information’ board, with information about local support groups and initiatives designed for carers.

Patients told us they were supported by the staff to access emotional support services when they needed them.

The doctor in the practice consulted then referred patients to alternate or additional services as necessary.

Condolences cards and calls were sent to bereaved families. News of bereavement was shared with the staff team, and staff contacted the family members to express their condolence for those patients they knew well. News of patient bereavement was placed on their patient record, so the staff team had access to this information and were able to offer the family additional support as necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used a risk tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice maintained a palliative care register and had regular internal, as well as multidisciplinary, meetings to discuss patient and their families' care and support needs. Monthly palliative care meetings were attended by members of staff in the practice, district nurses, the health visiting team, local hospice and the primary care coordinator. The minutes we reviewed relating to these meetings showed patients were discussed and how to continue to provide the care and support they needed at all times, and to ensure they were made as comfortable as possible.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

We found the practice understood and was responsive to the needs of different groups in their patient population. For teenagers, they found that their main concern was smoking and sexual health. Appointments were available outside school hours. In addition the practice referred patients to smoking cessation advice services, specifically for younger people. The practice also provided initial advice and onward referrals for sexual health services. Free test kits for Chlamydia were available in the practice.

Housebound patients were offered annual visits, and the administrative team monitored and ensured that these visits were arranged and carried out. To improve healthcare access for housebound patients, over the phone prescriptions were taken from this group. The practice worked jointly with the district nursing team to ensure housebound patients received annual flu vaccinations. The practice provided a list to the district nursing team of housebound patients, and followed up with them to ensure the vaccinations were completed.

The practice received weekly lists of patients seen by the district nursing team, and received a summary of the care given and any prescription requests from them. This information was used to update the patient care record.

All patients requiring referral in the borough must be directed through the Croydon Referral Support Service (CRESS), a system providing a single point of access for all referrals, except paediatrics, psychiatry and breast care.

A list of housebound patients was maintained in the practice and there was a designated staff member responsible for monitoring the list. The staff member attended relevant meetings where patients on the housebound list were discussed and updated their records accordingly to ensure they were up to date in terms of the care, treatment and support they received, and any follow ups and other services were arranged.

The practice team liaised with the community mental health team to ensure people received specialist mental health services where required.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from its Patient Participation Group (PPG). One example was that they had increased their provision of daily available emergency appointments in response to feedback from their PPG.

Home visits or longer appointments were available to patients who had that need, including older people and people with long term conditions.

Appointments were available outside of school hours and typical working hours for children, young people, and working people. There was suitable premises for children and young people, and referrals to sexual health clinics and smoking cessation services

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice understood the needs of their patients of working age, and offered extended opening hours and specific clinics to address their needs.

For people whose circumstances may make them vulnerable and people experiencing poor mental health, there was partnership working to understand the needs of the most vulnerable in the practice population, and longer appointments for those that need them.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example people with learning disabilities, carers and young people. Additional reviews were offered and provided to those patients with long term conditions to ensure their physical health was not neglected. Medication reviews were offered to patients on repeat and long term medications to ensure their treatment remained appropriate. Specific clinics were available for people with specific conditions, such as diabetes and asthma. The practice implemented national public health programmes and provided services such as immunisations and cervical screening.

The practice had access to online and telephone translation services. A face to face interpreter could be arranged with prior notice from the patient.

There was a register maintained of people who may be living in vulnerable circumstances. The patient records system flagged up patients' vulnerability status in their record, so that when appointments were made for them they could have longer appointments if necessary.

People in vulnerable circumstances were discussed as part of multidisciplinary meetings and arrangements were made to offer them continued support and prevent their neglect.

Access to the service

The practice leaflet was available in the practice waiting area, and held details of the opening times and appointment hours available in the practice and the branch surgery. Appointments were available at Addiscombe Road between 9am and 11.30am, then 4pm to 5pm on Mondays, Thursdays and Fridays, 9am and 11.30am only on Tuesdays, and 9am and 11.30am, then 5pm to 7.30pm on Wednesdays. Appointments were available at the branch surgery between 11.30am and 1.30pm, then 5pm to 6.30pm on Mondays to Fridays, with the exception of Wednesdays when there were only appointments between 11.30am and 1.30pm. The GP told us they offered the later appointments to working people preferentially to allow them to see the GP after work.

A number of appointment slots were reserved each day for emergency cases. Routine or non-emergency appointments were available to be booked up to six weeks in advance. The practice also operated a policy of seeing all under-five's on the same day if requested. Online appointments and repeat prescription request services were available in the practice.

Home visits were available to patients who could not attend the practice.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There were no baby changing facilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person, the practice manager, who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, including in the practice leaflet and on a notice displayed in the waiting area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at the two complaints that had been received in the last twelve months and found that they were satisfactorily handled and dealt with in a timely way.

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 GP articulated the practice vision as being to get patient satisfaction within the budget. The staff team we spoke with all held the shared values of delivering patient satisfaction through care, compassion and dedication to their work. However these values were not written down or documented for the patient population.

The principal GP sets a clear agenda for the practice manager and allowed her to execute the policies in the way she found most effective.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a sample of these policies and procedures and saw that they had been kept up to date and reviewed by stated deadlines. Policies and procedures relevant to new staff were covered as part of their induction training.

Members of staff attended monthly clinical commissioning group (CCG) meetings with other practices in their cluster. This allowed them to keep up to date with developments in the borough and in the CCG. Matters discussed at these meetings included changes to services which the practice needed to implement, such as care pathways, updates relating to their patient referral system and the joint adult mental health strategy.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had undertaken a number of clinical audits, for example a Vitamin D audit and a wound dressings audit had both been carried out in February 2013. Lessons learnt from the audits had been shared with the practice team to improve services for patients.

Leadership, openness and transparency

Staff told us they enjoyed working at the practice, felt very well supported, and had opportunities and support from the senior staff members to discuss issues.

The principal GP told us he encouraged an open, relaxed attitude, and welcomed staff approaching him for any issues.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of these, including the disciplinary procedures, induction policy, management of sickness, study and training policy and recruitment policy, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. New staff were provided with a copy as part of their induction.

Practice seeks and acts on feedback from users, public and staff

The practice had a patient participation group (PPG) which the practice was seeking to support in increasing its presence and activity. At the time of our inspection there were nine PPG members who met twice a year to share ideas for improvements to the practice. The practice was seeking to create a 'virtual' PPG that held their meetings online and discussed ideas electronically, such as via email and through the practice website. The manager explained that they were trialling this as a means of increasing PPG participation from different groups in their patient population.

We spoke with two members of the PPG. Their comments supported what the manager had told us. The PPG members gave examples of issues they had raised in the PPG meetings, and that the practice had listened and responded well to them, and made changes. For example they shared that after they discussed the difficulty of getting emergency appointments, these had now been made available in mornings and afternoons if needed. The PPG members also told us that they gave positive feedback

Are services well-led?

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

to the practice, as they particularly appreciated the continuity of care with many of the PPG members and the wider patient population having been patients of the practice for decades.

There were monthly staff meetings and monthly practice meetings, which were attended by the clinical team and all staff respectively. The staff team from the branch surgery also attended these meetings, and they took place when the surgery was closed. We reviewed the minutes of the latest practice meeting and found that the team had discussed a recent NHS local area team (LAT) infection control inspection, uniforms and dealing with prescriptions.

Staff received annual appraisals and had opportunity to comment on their performance, progress and their areas of interest for personal and professional development. We saw evidence that this feedback was responded to by the manager, who put arrangements in place for staff to have discussed learning and development.

Members of staff we spoke to told us they did not have structured one to one supervision meetings, but they had staff meetings. They told us they found these meetings useful.

The staff team were happy to support and cover for each other's absences, such as sick leave and annual leave.

Management lead through learning & improvement

Staff in the practice received relevant training for their roles. For example the administrative staff team had completed training in information governance, basic life support, and safeguarding adults. The practice nurse had completed training courses including venepuncture, child immunisation, infection control and human papilloma virus (HPV) vaccination. The nurse was also in the process of completing training to become a qualified midwife.

There was a study and training policy in place in the practice which set out the policy for staff undertaking a course of study, requesting a period of study leave, or requesting other facilities in relation to study, learning, training or continuing education.

Staff had opportunities to attend learning and training events organised by the clinical commissioning group (CCG). The manager kept up to date with events and training courses available and made provision for staff to attend these sessions. Recent courses that members of staff had attended included child protection, understanding investigations, payroll and accounts, and employment law.

The staff in the practice kept informed with the CCG protocols and published clinical guidelines. The practice manager shared how she kept staff informed about updates and changes to the protocols, and these were a regular feature of discussions at staff meetings.

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 Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The registered person did not operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character. Regulation 21 (a) (i). This is because, for the newest member of staff employed, a disclosure and barring service check had not been completed for them, and no references had been obtained for them.