Manor Road Surgery

Quality Report

14 Manor Road
Beckenham
Kent BR3 5LE
Tel: 020 8650 0957
Website: www.14manor-road.co.uk

Date of inspection visit: 15 November 2017
Date of publication: 29/12/2017

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?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Manor Road Surgery on 27 April 2016. As a result of our findings during that visit the provider was rated as good overall and requires improvement for providing safe services. The full comprehensive inspection report from that visit was published on 19 August 2016 and can be read by selecting the 'all reports' link for Manor Road Surgery on our website at www.cqc.org.uk.

The provider submitted an action plan to tell us what they would do to make improvements and meet the legal requirements. We undertook an announced comprehensive follow-up inspection on 15 November 2017 to check that the provider had followed their plan, and to confirm that they had met the legal requirements. As a result of our findings the provider is now rated as requires improvement for providing safe, effective, responsive and well-led services. Overall the practice is now rated as requires improvement.

Our key findings were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey were above average in all areas they showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The practice did not have clearly defined and embedded systems to minimise risks to patient safety.
  - Some staff had not completed role specific training, and there was no system in place to monitor staff training. Staff were having basic life support training every two years, instead of annually as recommended by Resuscitation Council (UK) guidance.
  - The practice was not conducting fire drills.
  - Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.
  - The practice had not conducted any practice meetings since March 2017.
  - All clinical staff had up to date appraisals, however non clinical staff had not had an appraisals carried out since March 2016.
  - There were no cleaning schedules.

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

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care:
- Ensure care and treatment is provided in a safe way to patients:

In addition the provider should:

- Consider conducting a risk assessment for not providing interpreting services.
- The provider should consider proactive strategies to set up a patient participation group (PPG).
- The provider should continue to review how patients with caring responsibilities are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Review role specific training for staff training and monitoring processes.

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.

- From the sample of documented examples we reviewed, we found there was a system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice, however not all significant events were being recorded. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice did not have clearly defined and embedded systems, processes and practices to minimise risks to patient safety. For example a Legionella risk assessment had not been conducted since 2012. The practice was not conducting fire drills. The practice had not conducted a health and safety risk assessment since 2012.
- Staff demonstrated that they understood their responsibilities and had received training on safeguarding children and vulnerable adults relevant to their role, however out of five files checked we did not see evidence that two clinical staff had child safeguarding training.
- Prescriptions were not being removed from printers in the evening.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Non-clinical staff were having basic life support training every two years, instead of annually as recommended by Resuscitation Council (UK) guidance.
- The infection control lead had not under taken any infection control training.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.

Summary of findings

- Staff had the skills and knowledge to deliver effective care and treatment.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.
- There was no evidence of appraisals and personal development plans for non-clinical staff since March 2016. However after the inspection the practice told us these had been conducted
- Some staff had not completed role specific training, for example basic life support, infection control, mental capacity and information governance, also there was no system in place to monitor staff training.
- There was no clinical quality improvement programme.
- Meetings were generally informal and record keeping was absent.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice facilities were equipped to treat patients and meet their needs. However due to the limitations of the building patients using a wheelchair, or walking frame would not be able to use the toilet.

Summary of findings

- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice leaflet could only be accessed if it was downloaded, and the information contained within it was out of date, for example listing clinical staff who had left the practice.
- The practice did not have a Patient Participation Group (PPG).
- The provider did not offer an interpreting services. The practice informed us this was due to the demographics of their local population.
- There were no baby changing facilities. The practice did have a baby change mat that patients could use, however there was no cleaning schedule for this.

Are services well-led?

Requires improvement

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

- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity.
- The practice lacked an overarching governance framework to deliver good quality care.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.
- The practice had not conducted any practice meetings since March 2017.
- There was no evidence of appraisals and personal development plans for non-clinical staff since March 2016. However after the inspection the practice told us these had been conducted.
- A health and safety and fire risk assessment had not been conducted since 2012.
- A Legionella risk assessment had not been conducted since 2012.

Summary of findings

- The business continuity plan needed updated as it contained out of date information and did not have staff contact or utility contact numbers.
- The practice leaflet and the practice website needed to be updated.
- The practice did not have a Patient Participation Group (PPG), however we were told the practice was trying to set one up.

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 provider was rated as requires improvement for safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible
- The practice looked after two nursing homes which they visited on a weekly basis.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The GPs had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable to the local and national average:
- 72% of patients with diabetes on the register had their blood sugar recorded as well controlled (local average 77%, national average of 78%). The exception reporting rate for the service was 9%, local 9% and national 13%.

Summary of findings

- 79% of patients with diabetes on the register had their cholesterol measured as well controlled (local 77%, national average 80%). The exception reporting rate for the service was 8%, local 10% and national 13%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice ran a weekly diabetic clinic.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of Accident and Emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, 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.
- The practice worked with midwives, health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

Summary of findings

- The needs of these populations 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 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.
- The practice provided a phlebotomy service.
- Patients were able to email queries and requests.
- Telephone consultations were also provided.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective, and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice had seven patients on the learning disability register, these patients had regular reviews rather than formal annual assessments.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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)

Requires improvement

The provider was rated as requires improvement for safe, effective, responsive and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

Summary of findings

- The practice carried out advance care planning for patients living with dementia.
- 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, (local average 82%, national average 84%).
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- 83% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (local average 83%, national average 90%). The exception reporting rate for the practice was 23%, local 7% and national 10%.
- 81% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the last 12 months local average 82%, national average 84%. (The exception reporting rate for the practice was 13%, local 5% and national 7%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing above local and national averages. Two hundred and thirty nine survey forms were distributed and 117 were returned. This represented 2% of the practice's patient list.

- 95% of patients described the overall experience of this GP practice as good compared with the CCG average of 83% and the national average of 85%.
- 90% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 78% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards which were all positive about the standard of care received.

We spoke with 7 patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice friends and family test from April 2017 to June 2017 feedback had six responses; all six patients were extremely likely or likely to recommend the practice.

Manor Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a second CQC inspector and an expert by experience.

Background to Manor Road Surgery

Manor Road Surgery is located in a large semi-detached house converted for the sole use as a surgery. The property is located in a mainly residential area of Beckenham, in theLondon Borough of Bromley. Services are provided from one location at 14 Manor Road, Beckenham, BR3 5LE.

Bromley Clinical Commissioning Group (CCG) is responsible for commissioning health services for the locality. The practice has 5700 registered patients. The practice age distribution is similar to the national average with a slightly lower than average number of patients 5 to 24 years and slightly higher than average number of patients 30 to 65 years. The surgery is based in an area with a deprivation score of 9 out of 10 (10 being the least deprived).

The practice is registered with the CQC as a partnership. Services are delivered under a General Medical Services (GMS) contract. The practice is registered with the CQC to provide the regulated activities of family planning; surgical procedures; maternity and midwifery services; treatment of disease, disorder and injury and diagnostic and screening procedures.

The provider's contractual arrangements include the provision of the following Directed Enhanced Services (DES): Childhood Vaccination and Immunisation Scheme; Facilitating Timely Diagnosis and support for people with Dementia; Minor Surgery; Rotavirus and Shingles immunisation and Unplanned admissions. (A DES requires an enhanced level of service provision above what is required under the core GMS contract).

Clinical services are provided by two full time GP partners (one female and one male) and a part-time salaried GP (female). There is a locum nurse and a permanent HealthCare Assistant (HCA). Overall the practice provides 22 GP sessions each week. The practice also employs a range of non-clinical support staff comprising of a practice manager, administrators and receptionists.

During the last seven months the practice had several key staff members leave. For four months the practice functioned as a single handed GP practice.

The surgery is open between 8am and 6.30pm Monday to Friday. Pre-booked and urgent appointments are available Monday to Friday from 8am to 6.30pm.

Why we carried out this inspection

We undertook a comprehensive inspection of Manor Road Surgery on 27 April 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We found that the provider was not meeting some legal requirements and they were rated as good overall and requires improvement in the safe domain.

We issued a requirement notice under the following regulation:

Regulation 12: Safe care and treatment

Detailed findings

We undertook a further announced comprehensive inspection of Manor Road Surgery on 15 November 2017. This inspection was carried out to ensure improvements had been made and to assess whether the practice had now met legal requirements.

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 carried out an announced visit on 15 November 2017. During our visit we:

- Spoke with a range of staff GPs, practice nurse, practice manager, administrative and reception staff, and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

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.

Requires improvement

Are services safe?

Our findings

At our previous comprehensive inspection on 27 April 2016, we rated the practice as, requires improvement for providing safe services as the appropriate infection control training had not been undertaken by the lead and an infection control audit had not been carried out in the previous 12 months. These arrangements had not improved when we undertook a follow up inspection on 15 November 2017. The practice remains rated as requires improvement for providing safe services**.**

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Although the practice had a system in place and carried out a thorough analysis of the significant events, we identified on the day of the inspection not all significant events were being recorded.
- From the sample of documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient had a history of chest pains they had an Electrocardiogram (ECG) (an ECG is one of the most common heart tests, which looks at heart rate), which result showed everything was fine. They then had a follow up ECG, which showed there were new changes, the patient left the practice before the results had been reviewed. When the GP realised what had happened the patient was contacted. The practice changed it process for reviewing information after an ECG, and now any reading other than normal the patient has to remain in the practice until a GP has seen them.

Overview of safety systems and process

The practice did not have clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The safeguarding policies needed to be updated, as they made reference to a GP that had left the practice, however they clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and however we did not see evidence on the day that two clinical staff members had child safeguarding training. One GP was trained to child protection or child safeguarding level 3. The practice nurse was trained to child protection or child safeguarding level 2. All non-clinical staff were trained to child protection or child safeguarding level 1. A notice in the waiting room advised patients that chaperones were available if required. Since the last inspection the practice changed its policy on who could act as a chaperone, to being only clinical staff, (however a member of staff we spoke with told us they conduct chaperone duties, but had not done so for a long time.) Chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

We observed the premises to be clean and tidy. However we found that the provider's infection

control processes were not in line with requirements of the Department of Health. There was no documented cleaning schedule and no cleaning records. Some of the chairs in reception were split, consequently could be an infection control issue. The practice provided its own baby changing mat, when we asked staff members how this was cleaned, they said parents usually bring their own mat, and there were no specific cleaning measures in place.

- The last health and safety risk assessment had been conducted in 2012.
- The last fire risk assessment had been conducted in 2012.
- The practice lead GP was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place but the lead GP and several staff members, (two clinical and one non-clinical) had not received up to date training. The lead GP had not had infection control training at the last inspection, an annual IPC audit had been undertaken (November 2017) and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms were not securely stored; they were left in printers overnight however there were systems to monitor their use. Patient Group Directions (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions (written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis) from a prescriber were produced appropriately.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Monitoring risks to patients

- The practice did not have an up to date fire risk assessments, the last one was conducted in 2012. After the inspection the practice confirmed they had booked an assessment for January 2018. The practice carried out a weekly fire alarm check. However, no fire evacuation drills had been carried out in the previous 12 months.
- There were procedures for assessing, monitoring and managing risks to patient and staff safety.
- There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice did not have a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The last legionella assessment had been conducted in 2012, and specified it should be reassessed in 2014.

Requires improvement

Are services safe?

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. A number of key staff had left over the last 12 months, the practice ensured they met patients' needs by using locums. They had now recruited a new GP partner in November 2017 and were actively looking for a practice nurse.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- We checked five staff records, three members of staff had not received annual basic life support training, this included two clinical (one GP and one health care assistant) and one non clinical. The practice advised they conducted basic life support training every two years. After the inspection the practice informed us that one member of staff had been booked to attend training at the end of November 2017. There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan needed to be updated as it did not include emergency contact numbers for staff, or suppliers.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our comprehensive inspection on 27 April 2016 we rated the practice, as good for providing effective services. These arrangements had changed when we undertook the follow up inspection on 15 November 2017, for example there was no evidence that audits were driving improvements in patients outcomes, staff were not up to date with role specific training. The provider is now rated as requires improvement for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

  The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 85% of the total number of points available compared with the Clinical Commissioning Group (CCG) average of 96% and national average of 96% with 9% (CCG average 8% national average 10%) clinical exception reporting. We sampled suitable records and found that the exceptions were appropriately reported. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.)

  This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2016/2017 showed:

  Performance for diabetes related indicators was similar to the CCG and national averages.

- 76% of patients with diabetes had well-controlled blood sugar levels in the previous 12 months (CCG average 73%, national average 78%). The exception reporting rate for the practice was 6%, CCG 8% and national 13%.
- 72% of patients with diabetes had well-controlled blood pressure in the previous 12 months (CCG average 75%, national average 78%). The exception reporting rate for the practice was 7%, CCG 7% and national 9%.
- 79% of patients with diabetes on the register had their cholesterol measured as well controlled (CCG average 77%, national average 80%). The exception reporting rate for the practice was 8%, CCG 10% and national 13%.

Performance for mental health related indicators was similar to the CCG and national averages.

- 78% of patients diagnosed with dementia had a recorded review in a face to face meeting in the last 12 months (CCG average 82%, national average 84%). The exception reporting rate for the practice service was 9%, local 6% and national 7%.
- 84% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the last 12 months local average 85%, national average 90%. The exception reporting rate for the practice was 27%, CCG 10% and national 12%. The practice explained the high exception rate was due to incorrect coding.
- 77% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the last 12 months (local average 85%, national 91%).The exception reporting rate for the practice was 23%, CCG 8% and national 10%. The practice explained the high exception rate was due to incorrect coding.

  There was limited evidence of quality improvement including clinical audit:

- There had been no full cycle clinical audits commenced within the last two years.
- The practice had conducted some single cycle audits looking at the reduction in prescribing antibiotics. Another audit looked at patients with dementia taking Anticholinergic medicines (Anticholinergics block acetylcholine - a chemical messenger found in your

brain and body), the practice reviewed patients and their medication and tried to reduce their medication, this audit demonstrated change, however there was no second cycle.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.
- The learning needs of non-clinical staff had not been identified as none of them had an appraisals in the last 12 months, however the practice manager told us this was something they would be doing in the near future.The practice had not conducted any practice meetings since March 2017 or reviewed practice development needs, there was no system in place to monitor staff training.
- Staff had not recently received training that included: safeguarding, basic life support, information governance and mental capacity act training. Staff did not have access to e-learning training modules, however the practice manager told us this was something they planned to do in the future. We reviewed five training records and found two clinical and one non-clinical staff had not had this training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 75%, which was comparable with the CCG average of 81% and the national average of 81%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend the national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice's uptake for females, 50-70, screened for breast cancer in last 36 months was 74%, which was comparable with the CCG average of 75% and the national average of 73%.

The practice's uptake for persons, 60-69, screened for bowel cancer in last 30 months was 56%, which was comparable with the CCG average of 57% and the national average of 58%.

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

Childhood immunisation rates for the vaccinations given were above the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice achieved above the target in all four areas. These measures can be aggregated and scored out of 10, with the practice scoring 9.1 (compared to the national average of 9.1).

- 92% of children aged 1 year had received the full course of recommended vaccines (expected standard 90%).
- 90% of children aged two years had received the pneumococcal conjugate booster vaccine (expected standard 90%).
- 90% of children aged two years had received the haemophilus influenzae type b and meningitis C booster vaccine (expected standard 90%).
- 92% of children aged two years had received the measles, mumps and rubella (MMR) vaccine (expected standard 90%).

Good

Are services caring?

Our findings

At our previous comprehensive inspection on 27 April 2016, we rated the practice as good for providing caring services. At this inspection we looked at caring and found that it continued to perform well.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. This facility needed to be requested by patients as it was not advertised.
- Patients could be treated by a clinician of the same sex.

All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with seven patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 82%
- 94% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 96% of patients said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 90% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared with the CCG average of 87% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals.

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

Good

Are services caring?

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 80% and the national average of 82%.
- 95% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 84% and the national average of 86%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that an interpretation service was not available for patients who did not have English as a first language. Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 45 patients as carers (0.8% of the practice list). This had increased since the last inspection when the practice had identified 36 patients as carers. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous comprehensive inspection on 27 April 2016, we rated the practice as good for providing responsive services. These arrangements had changed when we undertook the follow up inspection on 15 November 2017, for example there was no Patient Participation Group (PPG). The practice leaflet could only be accessed if it was downloaded, and the information contained within it was out of date. The provider did not offer interpreting services.

Responding to and meeting people's needs

- The practice provided out of area registration.
- The practice had a weekly antenatal clinic run by midwives.
- A phlebotomy service was provided by the practice.
- The practice did not provide extended hours service, however the practice had access to the Bromley GP Alliance GP hubs where they could offer patients appointments in the evening and on the weekend.
- The practice did not offer an interpreting service. The practice informed us this was due to the demographics of their local population
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There was a hearing loop.
- The practice provided a mat for baby changing facilities, however there was no cleaning schedule for this.
- The practice leaflet had to be downloaded and contained out of date information, for example it made reference to two clinical staff that had left.

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday. Appointments were available with the GPs from 8am to 11am 1.30pm to 2.30pm and 4.30pm to 6.30pm Monday to Friday. In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above average compared with local and national averages.

- 82% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 86% of patients said they could get through easily to the practice by phone compared with the CCG average of 72% and the national average of 71%.
- 89% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 85% and the national average of 84%.
- 94% of patients said their last appointment was convenient compared with the CCG average of 81% and the national average of 81%.
- 90% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 78% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 57% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 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 looked at five complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a patient complained about a member of staff being rude. The practice manager spoke with the member of staff and discussed effective ways of communicating with patients, so patients did not feel that staff were rude and not listening, the patient received an apology.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 27 April 2016, we rated the practice as good for being well-led. When we conducted this inspection we identified systemic weaknesses in governance systems such as ineffective monitoring of procedures. The practice is now rated as requires improvement for being well-led.

Vision and strategy

- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

At this inspection we found:

- The practice did not have clearly defined and embedded systems to minimise risks to patient safety.
- Not all significant events were being recorded.
- Some staff had not completed role specific training, and there was no system in place to monitor staff training. Staff were having basic life support training every two years, instead of annually as recommended by Resuscitation Council (UK) guidance.
- The practice was not conducting fire drills.
- Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.
- The practice had not conducted any practice meetings since March 2017.
- There was no evidence of appraisals and personal development plans for non-clinical staff since March 2016. However after the inspection the practice told us these had been conducted.
- There was no cleaning schedule.
- A health and safety and fire risk assessment had not been conducted since 2012.
- A Legionella risk assessment had not been conducted since 2012.
- The practice leaflet could only be accessed if it was download, and the information contained within it was out of date, for example listing clinical staff who had left the practice.
- There was no locum pack for locum staff.
- The business continuity plan needed updated as it contained out of date information as well as it did not have staff contact or utility contact numbers.
- The practice did not have a Patient Participation Group (PPG), however we were told the practice was trying to set one up.

Leadership and culture

Staff told us the lead GP was approachable and always took the time to listen to all members of staff.

The lead GP was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The lead GP encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the lead GP and practice manager. All staff were involved in discussions about how to run and develop the practice, and the lead GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

- The practice friends and family test from April 2017 to October 2017 feedback had five responses, all five patients were extremely likely to recommend. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

Are services well-led?

Requires improvement

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

There was a focus on continuous learning and improvement at all levels within the practice. The practice had just recruited a new GP partner; they were trying to recruit a practice nurse. The lead GP intended on restarting teaching F2 students. The practice was training their health care assistant (HCA) to full capacity. The practice was looking at offering skype consultations. The practice was also working with the CCG to develop their business continuity plan.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not do all that was reasonably practicable to mitigate any such risks. For example • Not all staff were up to date with role specific training, including basic life support, infection control and information governance, and mental capacity. • No fire drills were being conducted. • There were cleaning schedules or records. • Prescriptions were left in the printers overnight and not locked away. • A health and safety risk assessment and fire risk assessment had not been conducted since 2012. • A legionella risk assessment had not been conducted since 2012. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems or processes did not enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

- There was no evidence that audits were driving improvements to patient outcomes.
- The practice was not conducting meetings, consequently records were not kept.
- The patient information leaflet contained out of date information.
- There was no evidence of appraisals and personal development plans for non-clinical staff.
- The Infection Control lead, had not had any infection control training.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.