

Woodlands Primary Care

Quality Report

146 Halfway Street
Sidcup
Kent
DA15 8DF

Tel: 020 8300 1680

Website: www.woodlandssurgerysidcup.nhs.uk

Date of inspection visit: 15 July 2015

Date of publication: 15/10/2015

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10

Detailed findings from this inspection

Our inspection team	11
Background to Woodlands Primary Care	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Woodlands Primary Care on 15 July 2015. Overall, the practice is rated as good.

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.

Our key findings were as follows:

- There were systems in the practice to ensure safe care, which was supported by detailed policies.
- The practice reviewed untoward incidents and applied lessons learned.
- The practice building was clean and had been designed to ensure that it was fit for purpose.
- The records and audits that we saw showed good outcomes for patients in line with national averages. Both proactive and reactive audits were in place at the practice.

- Multidisciplinary meetings were held and care was planned and shared with healthcare providers in the community.
- Patients at the practice stated that they were treated with dignity and respect, and that access to the surgery had improved following the introduction of walk in clinics.
- Information about services and how to complain was available and easy to understand. This included the practice's website which was thorough, clear and informative. Appointments could be made and prescriptions requested online.
- There were clear vision and values in place at the practice which involved all staff.
- Staff at the practice understood their roles and responsibilities and line management arrangements were clear.
- There was a culture of openness and learning at the practice, and staff reported that they felt able to raise any issues of concern.

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

Summary of findings

Importantly, the provider should:

- Ensure that personal development plans for staff in the practice are signed by the appraiser and the person being appraised.
- Keep accurate records of checks and tests such as fire alarm tests and cleaning checklists.

- Ensure that clinical staff in the practice undertake life support training annually.

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 good at providing safe services.

Staff understood their responsibility for raising concerns, and the practice demonstrated learning from clinical incidents and near misses. Examples were provided of how services had been changed following review. There was an open culture at the practice and communication lines with staff were clear

The practice had leads in place in a number of areas including safeguarding, and all staff had been trained in this area and were aware of their responsibilities. Other risk management processes were well developed and were supported by policies.

Infection control policies in the practice were in place and the nurses were lead for this area. However, the treatment rooms in the practice had yellow topped sharps bins only. They had not checked whether or not orange or purple topped bins were required. The practice was clean throughout, and clinical equipment was serviced regularly and well maintained. Medicines management systems were in place at the practice. Storage of medicines and vaccines was appropriate.

Staffing levels in the practice met the needs of the practice population.

The practice had effective health promotion and preventative care systems in place.

Good



Are services effective?

The practice is rated as good for providing effective services.

The practice had scored 100% in the Quality and Outcomes Framework (QOF) for the previous year, and record reviews showed that patients were being reviewed and were receiving good care. Patients' needs were assessed and care was planned and delivered in line with current legislation.

The practice had a system of audit that included proactive review and reactive audits following clinical incidents. QOF criteria were reviewed through the year to ensure patients were well managed.

Meetings took place regularly at the practice. Some involved clinicians, others all staff, and there were also multidisciplinary team meetings with healthcare providers in the community. At clinical

Good



Summary of findings

meetings, new guidance was discussed as were significant events and individual patient care. Representatives from the practice also met regularly with other local healthcare providers and the Clinical Commissioning Group (CCG).

All staff were supported in professional development and a training matrix was kept to ensure that mandatory training was completed. Appraisals were in place but they were not detailed and signed by the appraiser or the person being appraised.

Are services caring?

The practice is rated as good for providing caring services.

The patients we spoke with said that they were always treated with dignity and compassion. They told us that doctors gave them enough time and involved them in decisions relating to their care. Patients said they were happy with the standard of service provided by the practice. This was also reported in the most recent national patient survey.

Comments received by patients who had attended the practice in the two weeks before the inspection were also positive, particularly relating to the help and support offered by all staff. This was also noted by the team during the inspection visit. Information for patients and carers was available both in the waiting area and on the website.

Patient feedback from the last national patient survey was positive in most domains.

Good



Are services responsive to people's needs?

The practice was rated as good for providing responsive services.

The practice had worked closely with the clinical commissioning group (CCG) to better understand its practice population. It had taken steps to improve the service following patient feedback, most specifically having a walk in hour every morning in response to feedback about poor access to appointments.

The practice offered a combination of same day and pre-bookable appointments. All clinical areas of the practice were accessible to patients. The practice was accessible to wheelchair users and the practice had processes in place to assist patients with hearing disabilities, and those patients who did not speak English as a first language.

An complaints system was in place at the practice and there were examples of services being further developed in response to complaints.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well led.

The practice had a clear strategic vision based around quality, safety and learning. The details of the practice vision developed over time. Staff in the practice were aware of the practice vision, and stated that they were clear on their roles and what was expected of them. Staff also described how they contributed to the practice vision.

Clinical and management leads were in place for specific areas of clinical practice, as well as for the development of policies and systems. Members of staff at the practice were all aware of who they needed to contact in specific situations. There were meetings in the practice for all levels of staff who reported that communication lines were clear. Line management reporting in the practice was clear and all of the records that we reviewed showed staff in the practice had already received their appraisal for last year.

The practice involved both staff in the practice and patients in how they were looking at developing the practice in the future. Staff stated that they were aware about who they needed to contact to escalate concerns. Changes had been made to the way the practice worked in response to feedback from the Patient Participation Group (PPG).

Good



Summary of findings

The six population groups and what we found

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

Older people

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

The practice had a relatively high population of older patients. The practice provided personalised care through their Admissions Avoidance scheme, which offered older patients enhanced access to telephone consultations, surgery appointments and home visits.

The practice showed that they had encouraged older patients with multiple health problems to make longer appointments so that their extra needs could be fully addressed. Home visits were provided to house bound older patients.

The practice had access to a community geriatrician based at the local hospital who could assist the practice in providing care for elderly patients with complex needs. The practice could also make referrals to the Bexley Rapid Response team, who were able to arrange social services, physiotherapy and occupational therapy input at short notice to support elderly patients in their homes.

We saw that regular multi-disciplinary meetings were in place with district nurses and palliative care teams, and the lead for the latter attended quarterly round table palliative care meetings. The practice also held a register to facilitate information sharing with emergency services for the benefit of patients undergoing end of life care.

Good



People with long term conditions

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

The practice nurses led the delivery of care to patients with chronic conditions. One of the GPs at the practice was lead for the management of diabetes and worked with the nurses to provide services for patients with diabetes. The practice also worked closely with the community diabetic nurse, holding joint diabetes reviews for more complex patients.

All patients with chronic conditions had an annual review, which included encouraging patients to better manage their own condition.

The practice had employed two prescribing officers to help manage repeat prescriptions in the surgery and processes to ensure safe prescribing and correct monitoring for patients who took warfarin or immunosuppressive medication were in place.

Good



Summary of findings

Families, children and young people

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

The local midwifery team held a weekly antenatal clinic at the surgery. Three of the GPs in the practice who had a background in paediatrics and/or obstetric care also provided post natal and baby checks.

Practice staff met regularly with health visitors to discuss children or families where there were known safeguarding issues. All staff in the practice had undertaken Level 1 child protection training and the GPs and nurses were trained to Level 3. The safeguarding lead in the practice attended quarterly meetings with Bexley safeguarding leads. The practice had recently audited notifications of children who fail to attend hospital appointments and had made amendments to their policies to better follow up these patients in the future.

The practice offered contraception services including the fitting and removal of coils and sub-dermal contraceptive implants as part of an enhanced service.

Good



Working age people (including those recently retired and students)

The practice is rated as good for services to working age people (including those recently retired and students).

The practice used daily telephone consultations and the use of email as a means of communication. Patients in the practice were able to book appointments and request prescriptions online, where the patient could pick up prescriptions directly from the pharmacist. The practice had a text messaging service in place for appointment reminders with the facility to make cancellations via text message.

The practice website contained links to a large amount of health promotion advice.

Good



People whose circumstances may make them vulnerable

The practice offered good services to people whose circumstances may make them vulnerable

The practice had a system that ensured that each year one of the practice nurses visited housebound patients for checks relating to chronic conditions.

The practice had a register of patients with learning disabilities. They contacted patients to offer annual hour long health check as part of

Good



Summary of findings

an enhanced service. Where patients had refused the health check it was recorded on the patient record and the register. The practice also offered extended appointments for patients with learning disabilities.

The practice also held a register of carers and the local carer support services was advertised on both the website and in the waiting room.

The practice had held a recent adult safeguarding training course for all staff to ensure they were aware of the signs of potential abuse in vulnerable patients.

People experiencing poor mental health (including people with dementia)

The practice offered good services to people experiencing poor mental health.

The practice shared care locally with community mental health services and the local voluntary support group. The practice also held a register of patients with mental health problems and these patients were offered an annual review including a physical health check.

The practice also held a register of dementia patients who were also offered annual health reviews. The practice had recently hosted teaching sessions by the community mental health team in order to educate staff about dementia. The practice had also arranged for a representative from a specialist organization to deliver further staff training as well as an evening session for the PPG and interested patients.

Good



Summary of findings

What people who use the service say

We spoke with nine patients during our inspection and we received 10 Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the two weeks prior to the CQC inspection.

All of the patients we spoke with said practice staff were helpful and they were treated with dignity and respect. They reported that staff explanations were very clear and that both doctors and nurses involved them in their care. Overall, all of the patients we spoke with reported that the practice had provided them with a good service.

Four of the patients noted the new walk in appointments that had been offered to patients had made accessing GPs substantially easier and they felt the practice had improved as a consequence.

The 10 comment cards we received were similarly positive about the service being provided by the practice. Three of the cards stated the practice provided an excellent service, and four stated that all staff in the practice (both clinical and administrative) were caring and helpful. Three of the cards were from patients with long term conditions who reported that practice staff were patient with them and had helped them come to terms with difficult illnesses.

The practice had received 121 responses to the 2014 national GP patient survey (published 2015). In many areas the practice scored similarly to other practices in the clinical commissioning group (CCG) area and the national average. Of particular note was that 80% of

those questioned rated their overall experience at the practice as good, compared to a national average of 83% and a CCG average of 78%. However, the practice did score lower than other practices in the area of waiting times and access to the practice. Particularly relevant statistics were as follows:

- Ninety per cent of respondents said the last GP they saw or spoke to was good at listening to them, compared to a CCG average of 86%.
- Ninety nine per cent of respondents said that they had confidence in the last GP that they spoke to, compared to a CCG average of 93%.
- Thirty five per cent of patients reported that they waited 15 minutes or less to see a doctor, compared to a CCG average of 57%.
- Fifty one per cent of patients reported their experience of making an appointment as good, compared to a CCG area average of 64%.

The practice had tried to organise a patient participation group (PPG) that could meet in person, but despite actively advertising it to patients they had not been able to attract sufficient interest to make a meeting viable. The practice had therefore decided to implement a “virtual” PPG which worked online and allowed patients to respond to any changes that the practice wanted to implement by e-mail. It also allowed a forum for feedback to be provided.

Woodlands Primary Care

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a CQC inspector, a GP specialist advisor, and a practice manager specialist adviser. The inspection team members were granted the same authority to enter the practice as the CQC lead Inspector.

The inspection took place over one day, and we looked at care records, spoke with patients, six and a number of practice staff. This included GPs, the practice manager, practice nurses and reception staff.

Background to Woodlands Primary Care

Woodlands Primary Care is in Sidcup in the London Borough of Bexley which covers an area in both South East London and parts of North West Kent. The practice has four GP partners who manage the practice which is based at a single site. The practice is based in a converted house which is owned by the practice. The building has been renovated to ensure that it is fit for clinical use, and has been extended to accommodate further consulting rooms.

The practice provides services to approximately 10,000 patients. The age demographic for the practice population is broadly in line with national averages, as was average life expectancy.

The practice employs one salaried GP, and because it is a training practice there were also two trainees in post at the

time of the inspection visit. The GP partners in the practice share lead responsibilities across a range of clinical domains, for example safeguarding, management of diabetes and governance.

The practice employs two nurse practitioners, three other practice nurses and two healthcare assistants. A phlebotomist attends the practice three days a week for one hour. District nurses, Health Visitors and Midwifery services are also available at the practice.

The practice employs a practice manager and an assistant practice manager. There were also eight receptionists, two prescribing clerks, two secretaries, a lead administrator and an administrator.

The practice is contracted to provide Personal Medical Services (PMS) and is registered with the CQC for the following regulated activities: treatment of disease, disorder or injury, maternity and midwifery services, family planning, surgical procedures and diagnostic and screening procedures.

The practice provides a range of enhanced and additional services including childhood vaccination, influenza and pneumococcal immunisations, learning disabilities, minor surgery, and rotavirus and shingles immunisations.

The practice is open five days a week from 8:00am to 6:30pm. Out of hours services for the practice are provided in partnership with an external agency when the surgery is closed. The practice operates a booked appointment system, but patients could attend a walk in clinic from 11am every day on a first come first seen basis.

Detailed findings

Why we carried out this inspection

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

From April 2015, the regulatory requirements the provider needs to meet are called Fundamental Standards and are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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:

- Is it safe?
- Is it effective?
- Is it caring?

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England and Bexley Clinical Commissioning Group (CCG) to share information about the service. We carried out an announced visit on 15 July 2015. During our visit we spoke with patients and a range of staff which included GPs, practice manager, nurse, and receptionists. We looked at care records, and spoke with the management team. We spoke with nine patients who used the service, and received comment cards from a further 10 patients. We also observed how staff in the practice interacted with patients in the waiting area.

As part of the inspection we reviewed policies and procedures and looked at how these worked in the practice.

Are services safe?

Our findings

Safe track record

The practice had systems in place for maintaining patient safety. There were a range of formal meetings in place at the practice. Minutes of clinical meetings (held weekly) showed that developments at the practice were regularly discussed, and learning points from significant event analysis was shared with all relevant staff in the surgery. All staff meetings were held three times per year, however administrative staff reported that if an urgent issue arose then they would normally meet with the practice manager on an ad hoc basis.

National Institute for Health and Clinical Excellence (NICE) guidelines were reviewed and circulated by the practice. All staff in the practice were aware of whom to raise concerns with if they had concerns in relation to the care being provided.

We reviewed safety records, incident reports and minutes of meetings where these were discussed in the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice was able to show that serious events were recorded and analysed and any learning points were integrated into providing improved care. The practice had apologised to patients where required.

Learning and safety was a standing agenda item on the monthly multi-disciplinary team meetings. We saw three significant event reviews from the past year. In all of the serious events reviewed the practice had been open with patients and had shared learning with all of the practice staff. An example provided was that a patient had attended for a blood test and a nurse had entered the room during the consultation without knocking. All staff were reminded following the incident to knock on doors where consultations may be taking place. The practice kept a log of all significant events and minutes of all meetings where they were discussed.

The practice maintained a risk register for clinical events with review dates as necessary.

Reliable safety systems and processes including safeguarding

The practice had a lead for safeguarding, managing both issues relating to children and vulnerable adults. The safeguarding lead was one of the partners in the practice who met with health visitors on a regular basis. All staff in the practice were aware of who was lead for safeguarding, including those staff who did not generally see patients. All staff were also aware of signs of abuse and knew when they would need to escalate concerns to the safeguarding lead. Records of vulnerable patients at the practice were clearly flagged on the database, and a register of these patients was also available. Policies were in place for safeguarding of both children and vulnerable adults.

All clinical staff in the practice had been trained in child protection to Level 3, with administrative staff (including those who did not routinely come into contact with patients) to Level 1. Contact numbers for local safeguarding teams were available for all staff. Staff had also been trained in the Mental Capacity Act 2005, details of which were recorded on both individual staff records and a practice training matrix. All staff in the practice had also received a Disclosure Barring Service (DBS) check, copies of which were available on staff files.

Several of the receptionists at the practice acted as chaperones during consultations. Two of the staff had been formally trained and had trained other staff undertaking this role.

The practice had systems in place to follow up vulnerable patients who may regularly attended Accident and Emergency, as well as any young or vulnerable patients who regularly did not attend appointments.

Medicines management

Medicines management processes were in place at the practice. Anaphylaxis kits were available in all rooms in which vaccinations were given. A range of vaccines and other medicines were available in the practice. All medicines we saw were in date and there was a system in place to order replacements. Where required, medicines were kept in refrigerators that were fit for purpose, and temperature checks had taken place and were clearly logged. No controlled drugs were kept on the practice premises.

Are services safe?

There were clear processes in place for repeat prescribing in the practice. Repeat prescriptions were managed by two prescribing clerks and the doctors. Staff who were involved in the process were aware of when a recall of patients was required either for a regular review or for blood tests. There was a system in place for the management of high risk medicines such as warfarin, which require regular monitoring in accordance with national guidance. The practice had completed a number of audits of long term medicines management including for renal function tests and the use of diuretics. Prescription pads were kept in locked cupboards and in consulting rooms. We observed that doctors locked their consulting rooms when they left them. A log of prescription pads was also kept in the reception area of the practice.

The practice had patient group directions (PGDs) in place. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment by a registered nurse.

Cleanliness and infection control

The practice premises were noted to be clean during the inspection. The practice was based in a former residential property and renovations had occurred to ensure the premises were fit for purpose. The infection control leads for the practice were the practice nurses. There was an infection control policy in place and staff reported that cleaning processes were in place at the practice. However, cleaning schedules were not thoroughly documented.

All seating in the waiting area was plastic so that it could easily be cleaned. Equipment in clinical rooms such as examination couches, scales and blood pressure monitors were also noted to be clean, and disposable rolls of paper were available to minimise the risk of cross infection.

Clinical spill kits were in place in the practice and all staff were aware where they were kept. Disposable gloves and hand washing gel were available in all of the clinical rooms.

Clinical waste disposal bins and sharps disposal systems were available in all of the consulting and treatment rooms. However, only yellow sharps disposal bins were available throughout the practice. The practice policy called for purple and orange bins to be in place but they were not. As

such the practice was not operating within its own policy. Locked bins were kept outside of the practice and a contract was in place to ensure that clinical waste was collected on a regular basis.

The practice had recently been assessed for Legionella and no action had been required (Legionella is a bacterium found in the environment which can contaminate water systems in buildings).

Equipment

There was equipment in place in the practice to ensure that good clinical care could be delivered. The practice had contracts with external contractors to ensure that where required equipment was calibrated on a yearly basis. We observed that equipment that required calibration (such as weighing scales, spirometers and blood pressure measuring devices) had last been checked in March 2015. Fire extinguishers in the practice had also been serviced on a yearly basis. All electrical equipment in the practice had been portable appliance tested (PAT) to ensure that it was safe for use.

Staffing and recruitment

Staffing and recruitment at the practice was appropriate. Policies and protocols in the practice were developed and review dates were included where required. All staff were aware to find policies on the practice and were aware of their responsibilities. Staff records contained thorough details of training undertaken and copies of relevant recruitment documents were maintained. Background checks such as that for the Disclosure Barring Service were also kept on file.

The practice had a large number of longstanding staff, with several staff having been at the practice for at least ten years. All staff that we spoke with reported that although there were busy times at the practice, overall there were sufficient staff to deliver care to the practice participation. There were sufficient cover arrangements in place to ensure that the service could still be delivered if staff were absent.

Monitoring safety and responding to risk

A schedule of risk assessments were in place, managed by the practice manager and the assistant practice manager. A fire risk assessment had been carried out and this was due

Are services safe?

to be reviewed following the next scheduled improvement work on the building which was being planned at the time of the inspection. We were told that fire alarms were tested weekly but there was no record kept of these tests.

A health and safety policy was in place at the practice which detailed responsible parties. There was a record that all staff in the practice had read this policy. The practice also had a zero tolerance policy, a copy of which was prominently displayed in the patient waiting area. This was also included in the practice leaflet and on the website. Staff were aware of the policies and they had undertaken training.

Arrangements to deal with emergencies and major incidents

A business continuity plan was in place in the practice, which included “buddying” with a practice about a mile away. Copies of the plan were kept on site, but also at the homes of several members of staff who could therefore access them where required.

The practice had systems in place to manage any on site medical emergencies. An Automated External Defibrillator (AED, which is used to re-start a patient’s heart) was available as was oxygen. Both had been maintained to ensure they were fit for purpose and all staff at the practice were aware of where they were kept. Staff in the practice had been trained in basic life support, with clinical staff being trained every 18 months and non-clinical staff every three years. Clinical staff should be trained every 12 months.

Emergency medications were also available in the practice. Medicines were kept in secure clinical locations. There were medications in place to treat either cardiac arrest or anaphylaxis. As with all medicines in the practice, medicine stocks were regularly checked to ensure that they were within their expiry date, and where expiry dates were near further stocks were ordered.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

National Institute for Health and Clinical Excellence (NICE) guidelines were regularly reviewed at clinical meetings in the practice. The practice provided examples of how guidelines for dermatology and the treatment of diabetes had been discussed in the clinical meetings and how practice had developed within the surgery as a consequence. Leads in specific areas (such as the treatment of patients with diabetes) had responsibility for leading on the discussion of new guidelines at practice meetings.

There were leads in place for the management of long term conditions as well as other relevant areas such as safeguarding. All of the GPs that we spoke to were aware of when follow ups of patients was required, either for medication reviews or blood tests. The practice also used local CCG guidelines on the use of antibiotics. Prescriptions of antibiotics in the practice had increased in the last year, but it was reported that this was due to locum doctors who prescribed them more regularly. The practice had ensured that prescribing of antibiotics was discussed with all locums.

The practice had risk profiled the population, and the choice of enhanced services was in part guided by this, particularly in the care of patients with diabetes of whom there were a high number at the practice.

Care plans were in place for vulnerable patients in the practice and these were agreed during consultations with patients. These patients had a named GP responsible for their care, and patients were provided with written summaries of how their care was being managed. Extended appointments were available for patients with learning disabilities. Over half of the patients with learning disabilities in the practice had received a health check in the previous 12 months. Of those that had not received a health check, in all but one of the cases it had been recorded that the patient had refused this.

The practice showed outcomes comparable to or better than the national average in managing long term conditions. For example, the percentage of patients with diabetes, on the register, in

whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months was 84% compared to 78% national average. Patients were also followed up regularly with 93% of diabetic patients having a record of an albumin: creatinine ratio test in the preceding 12 months compared to 83% nationally.

The practice had reviewed 93% of its patients with a diagnosis of dementia in the last year, compared to a national average of 84%.

Management, monitoring and improving outcomes for people

The practice had scored 100% on the quality outcomes framework (QOF) for the last financial year. Progress against QOF was regularly audited and discussed in team meetings to ensure that patients were receiving good care. Clinical leads were in place for many of the areas covered by QOF and responsibility was shared between all of the GPs in the practice.

The practice regularly collated and reviewed patient information to improve care. Notes from clinical meetings showed that where there were prescribing outliers these issues were discussed and where relevant individual doctors were told of changes that needed to be made.

The practice had a thorough system of audit. The practice provided three audits that had completed two full audit cycles. As well as pro-active audits the practice also implemented reactive audits following significant events. Following a significant event at a nearby practice, the practice had audited all “did not attend” (DNAs) at hospitals to ensure that good care was being provided. The audit was thorough and included several recommendations for the practice which they had implemented, including a new system for follow up. This included using the prescribing clerks in the practice to prompt doctors where follow ups were overdue.

Medicines and repeat prescriptions were issued and reviewed in line with NICE and other national guidelines. In the records reviewed and on the basis of the background information provided it was evident that patients had been followed up and that blood tests had been requested for a review of efficacy or where a change in medication was being considered.

Effective staffing

Are services effective?

(for example, treatment is effective)

Many of the practice staff were longstanding and had been at the practice for more than ten years. Some staff had been at the practice for less time, and all reported that induction into the practice had been appropriate and all staff were aware of their roles and responsibilities.

The practice used a training matrix for mandatory training, although other training was individualised. The staff we spoke with said they had been provided with time for training and were supported in their learning and development. Training in health and safety, child protection, infection control and basic life support was up to date for all staff.

All staff in the practice had received an appraisal for the last year and copies of appraisals were kept on staff files. However, the appraisals in the practice did not contain a comprehensive assessment of performance against specific domains, and appraisals were signed by neither the appraiser nor the person being appraised. All GPs were up to date with regulatory requirements for revalidation from the General Medical Council (GMC). (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the GMC can the GP continue to practise and remain on the performers list with NHS England). Nurse registrations were also up to date.

There were meetings in place between doctors and nurses at the practice to ensure that care was shared in a co-ordinated way for those patients with long term conditions. Minutes of meetings showed that care had been discussed.

Working with colleagues and other services

Clinical meetings were held once a fortnight at the practice. There was also a monthly multi-disciplinary meeting. Clinicians in the practice attended along with district nurses and palliative care providers. This meeting ensured that patients with complex illnesses, long term conditions, or those who were vulnerable could be reviewed with healthcare professionals providing care in the community.

Practice staff met regularly with other local practices and the clinical commissioning group (CCG). The lead for safeguarding met with other safeguarding leads within the area on a regular basis. The practice also worked closely with the CCGs Primary Care Development Group.

Notifications from the ambulance service, out of hours provider and the 111 service were received electronically and by post at the practice. A system was in place whereby the correspondence was scanned (if required) and flagged to the relevant doctor (either the named GP, or the lead for that area). Hospital discharge summaries were scanned onto system, or entered electronically, and passed to the GP. Changes in medications were managed by the GP with the assistance of a team of two dedicated prescribing clerks.

Referrals to secondary care were forwarded through the administrative staff at the practice. Once a template was complete the request was either faxed or e-mailed depending on to which service it was being sent. The secretarial team would call the hospital to ensure that they were in receipt of any urgent referrals.

Incoming results (such as radiology or pathology) were received directly onto the clinical system. All incoming correspondence was monitored by the administrative staff in the practice to ensure that any unmatched data could be shared with all of the doctors.

Information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results.

Consent to care and treatment

The clinical staff in the practice were aware of their consent responsibilities, including how to assess competency in line with the Mental Capacity Act (MCA). One of the clinicians was able to demonstrate how they had used the MCA requirements in the treatment of a patient with a disability. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a chaperone policy in place at the practice and a notice detailing the availability of chaperones was prominently displayed in the reception area. All of the staff that undertook chaperone duties had been checked by the

Are services effective?

(for example, treatment is effective)

Disclosure Barring Service (DBS). Although some of the staff who acted as chaperones had been formally trained, others had only received informal training from those who had attended the formal course.

Health promotion and prevention

Health promotion advice was available to patients in the practice. There were posters and leaflets in the reception area. Notice board displays focussed on specific illnesses or issues such that all relevant information could be found in one place. The practice's website also contained similar relevant information.

The practice held a weekly smoking cessation service. In the last year, of those patients who had attended they had achieved a 44% success rate, and as such had targeted 56% for the current year.

The rate of uptake for cervical smear testing was 84%, which was in line with the national average of 81%. The

practice also had a high uptake for influenza vaccinations. The percentage of patients in at risk groups aged 6 months to 64 years who had received a seasonal flu vaccination was 65%, higher than the national average of 52%. The uptake of bowel screening was 59% of patients over the age of 60.

Immunisation rates at the practice were over 70% for patients aged two years and five years, and 68% for patients up to the age of 12 months.

The practice had systems in place to support patients over the age of 75 who had their own named GP. GPs in the practice reported that they would proactively check health issues with older or more vulnerable patients. Care plans which had been reviewed in the last year were in place for 85% of the patients on the mental health register in the practice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During the inspection we noted that patient confidentiality was maintained. The reception area was slightly offset from the waiting room and as such any private conversations at reception could not be overheard. Staff were noted to treat patients politely and with respect.

The latest national GP surgery showed positive feedback in some areas. It showed that:

- Ninety three per cent of patients said that the last GP they saw or spoke to was good at listening to them, compared to a CCG average of 86% and a national average.
- Overall 80% of patients stated their experience of the practice was good, similar to the CCG average (78%) and the national average (85%).

The availability of chaperones was advertised on notices in the waiting area. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were aware of how to raise concerns about disrespectful behaviour, and zero tolerance notices were in place in both the practice leaflet and on a notice in the waiting room. Staff we spoke with said that they felt comfortable providing feedback, and they were aware how to do so.

A range of health promotion advice was available in the reception area, as well as details of the practice's patient participation group (PPG).

Care planning and involvement in decisions about care and treatment

The latest national GP survey showed that;

- Eighty per cent of patients said the last GP they saw or spoke to was good at involving them in decisions about their care compared to a CCG average of 78% and a national average of 81%.
- Ninety per cent of patients reported that nursing staff were good at explaining results and findings to them compared to a CCG average of 87% and a national average of 90%.
- Eighty per cent of patients reported that the last nurse they saw or spoke to was good at involving them in decisions about their care, compared to a national average of 84%.

Three of the responses on the CQC feedback forms specifically stated that they felt involved in decisions relating to their care, and two of the patients had complex long term conditions. The website contained information about how care could be accessed and how patients could communicate with the practice, including details about the practice's PPG, which was undertaken "virtually" by way of e-mail in order that more patients could be involved.

Staff told us that translation services were available for patients who did not speak English as a first language, but that these were not often required. There was also a link to an advocacy service on the practice website.

Patient/carer support to cope emotionally with care and treatment

The practice manager reported that in the event of a bereavement the practice would send a letter to the family and that bereavement counselling could be offered. There were posters in the waiting room detailing support services, and the website had a thorough list of support services including details of how they could be contacted.

The practice kept a register of carers. We were not able to speak to any patients who were carers, and no patients that were carers commented on the CQC feedback forms.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of its patients and had systems in place to ensure that the level of service provided was of a high quality.

The practice worked closely with the clinical commissioning group (CCG) and other practices in the area to ensure that it delivered good quality care to its patients. The practice had highlighted sexual health for younger patients as a particular issue. They had developed the sexual health service provided by the practice in response to this. Multi-disciplinary meetings at the practice ensured that providers in the community were involved in patient care.

The practice had instigated a walk in service between 10:00am and 11:00am every day in order to address access issues that had been fed back by patients through surveys and on an individual basis. They had ensured that double appointments were available to those patients with complex needs as well as vulnerable patients such as those with learning disabilities.

The national patient survey showed less favourable outcomes in terms of availability of appointments. It showed that:

- Fifty per cent stated that they found it easy to get through to the practice by telephone compared to a 73% national average.
- Fifty per cent stated that they found the process of making an appointment as good, compared to a national average of 73%.

Registers were in place at the practice to identify those people who might require more specialist medical help. These included patients with dementia and those who were housebound. These patients (as well as those over the age of 75) were also proactively provided with care plans and had a named GP at the practice.

The practice website provided information for patients including the services available at the practice, health alerts and latest news. There was an up to date list of practice staff. Information leaflets and posters about local services, as well as how to make a complaint, were available in the waiting area.

The practice had tried to organise patient participation group (PPG) meetings, but interest from patients had been limited. In response to this they had implemented a virtual PPG where feedback was sought from a broad range of patients when changes were made to the practice. This service was detailed to all new patients, and the practice stated that it had received feedback from more patients than it could have worked with in a conventional PPG. Details of the PPG were available in the practice leaflet and on the website.

Tackling inequity and promoting equality

The practice had taken steps to tackle inequality and promote equality.

The practice was based in a converted house. However, it had been extensively modified and extended, such that only one consulting room (which was reported as being rarely used) was on the second floor of the practice. When the room was in use, practice staff always checked whether or not the patient could use stairs, and if not the patient could be consulted in an alternative room. All waiting and clinical areas of the practice on the ground floor were accessible to all. One of the two toilets on the ground floor had been designed for wheelchair access. There were also baby changing facilities in place. A hearing loop was also available at the practice.

There were both male and female practitioners at the practice, and patients were given the option of booking appointments with either male or female doctors.

Housebound patients were reviewed on a yearly basis and there were prompts when follow ups were due. Patients with learning disabilities were also reviewed, and there was a record of where checks had been offered but refused. The practice had a register of those patients with dementia, and was in the process of reviewing patients who had memory lapses to ensure that they were receiving the best care possible.

Access to the service

The practice was open five days per week from 8:00am to 6:30pm, and appointments were available throughout the day. The practice operated a duty doctor system, plus a doctor who saw patients who attended the walk in service between 10:00am and 11:00am daily. Home visits and telephone consultations were shared between all of the doctors on any given day. The walk in service had been

Are services responsive to people's needs?

(for example, to feedback?)

introduced in response to feedback from patients and from the national patient survey that accessing appointments could be difficult. The patients that we spoke to during the inspection reported that access had improved since the service had been introduced.

The practice website contained relevant information about the practice including opening times. It also contained a wide variety of information leaflets about health promotion and specific conditions, which could easily be found on the website. Online repeat prescriptions could also be requested and could be picked up directly from a nominated pharmacy.

Information about the practice and out of hours contacts was available via the answer phone, and this information was also clearly available on the practice's website.

The feedback from the nine patients that we spoke to during the visit was positive. They commented that the staff were friendly and helpful, and several also noted that access to the practice was much improved since the introduction of the walk in system. All of the CQC feedback forms were also positive about how well patients felt treated by staff at the practice.

Listening and learning from concerns and complaints

The practice had systems in place for learning from complaints. The practice manager was the lead for complaints, although other staff in the practice would be involved if the complaint related to a clinical issue. Information on how to make a complaint was available in the reception area, in the waiting room and on the practice's website. Staff we spoke with were aware of the process and of what to advise patients if they wished to make a formal complaint. The practice had a policy of apologising to patients where required.

The practice kept a log of all complaints and audited complaints on an annual basis. The practice manager stated she always spoke to the patient, but that she also made a written record of any complaint for audit purposes.

From the sample of complaints reviewed by the inspection team it appeared they were managed appropriately and where necessary apologies were made to affected patients. A record of the response to the patient was also kept. Learning from events was shared with all staff at meetings which could be organised on an ad hoc basis if required. There were no themes in the complaints received.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear statement of purpose based around the delivery of high quality clinical care and the continuous development of the practice. One of the practice partners defined the practice strategy as being guided by the three principles of quality, safety and learning. All staff we spoke with were aware of the vision and values, most particularly issues of transparency and continuous improvement. Both managers and other staff at the practice told us they were encouraged to contribute at various levels of delivering a high quality service. The vision and values in the practice were under continuous development to fit in with business need.

Governance arrangements

The practice had governance arrangements in place. There were a wide range of policies and protocols in place at the practice of which all staff were aware. Where new policies were introduced we saw that they were discussed at team meetings. All policies we saw were in date and there were review dates in place.

The practice demonstrated an open response to feedback and we saw that both complaints and serious event analysis had been managed with a view to improving services.

The practice had completed a number of relevant audits, including several that were observed to have completed two full audit cycles. Some of the audits had been undertaken as part of a proactive and well defined system of audit, with others being in response to serious incidents or other feedback.

Leadership, openness and transparency

The leadership structure of the practice was clear, with staff in lead roles for key areas such as safeguarding, diabetes management, mental health and staffing. All staff we spoke with knew who these leads were. Staff reported that relevant information was shared with them, and if important information arose and there was no meeting scheduled it would be shared on an ad hoc basis. Administrative and reception staff reported that they were aware of their responsibilities, and they knew where any issues of concern could be raised.

There was an on-going review of the Quality Outcomes Framework (QOF) and in the last year this had led to the practice achieving a 100% score.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us a range of risk assessments that had been carried out where risks were identified and, where necessary, action plans had been produced and implemented.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had several systems in place to elicit patient feedback. The practice used a “virtual” PPG in order to involve more patients information was shared by e-mail and online. The practice had also acted on national patient surveys. Both the PPG and patient surveys had reported that access to appointments was an issue for patients. The practice had responded by overhauling how it arranged appointments by implementing a walk in clinic. Any patient attending the practice between 10:00am and 11:00am would be seen on the same day.

The practice also sought feedback from staff. Members of staff said they knew who to approach if they wished to raise an issue, and the practice manager told us the practice management took comments from staff seriously. The members of staff that we spoke with reported that they enjoyed working at the practice. The practice had a whistleblowing policy in place and all staff were aware of it.

Management lead through learning and improvement

One of the partners reported that learning was one of the three strategic aims of the practice. We found this to be the case when reviewing systems in the practice. Significant events were managed in line with a defined process. We could see how changes to practice had been put in place following serious events. Staff were open when discussing serious events, and the practice had instigated audits where required, an example being an audit of occurrences where children did not attend hospital appointments following a safeguarding issue.

Staff told us that they felt supported in their professional development. We were told that protected time for professional development was available for all staff, and those we spoke with had taken courses in areas relevant to their role.

Are services well-led?

Good 

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

The practice was involved in regular meetings with both local healthcare providers in the community, and with Bexley clinical commissioning group (CCG).