Highland Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Highland Medical Practice's main site (previously registered with the Care Quality Commission (CQC) as Dr Gnanachelvan & Partners) on 10 February 2015. As a result of our findings during that visit the provider was rated as requires improvement for providing safe, effective and well-led care, and it was rated as requires improvement overall. The full comprehensive inspection report from that visit was published on 30 July 2015 and can be read by selecting the 'all reports' link for Highland Medical Practice on our website at https://www.cqc.org.uk/location/1-549056430.

During that visit our key findings were as follows:

- The provider had not clearly documented discussions and learning from significant events.
- There were ineffective systems for assessing, monitoring and improving the quality and safety of the services provided.
- The provider had not adequately assessed or managed risks to service users.
- Several staff had not received key training, there were no records of appraisals for some staff, and inductions had not been documented for new staff.
- Performance for cervical screening was below the national average.
- Results from the national GP patient survey showed that patients rated the practice below average for some consultations with GPs and nurses.
- Appropriate recruitment checks had not been conducted and documented.
- Some policies were not fit for purpose and not all staff were aware of the whistleblowing policy.

This inspection on 10 January 2017 was conducted as an announced comprehensive inspection of the provider's main and branch sites to assess whether the provider had followed their action plan and was meeting the requirements. The provider expressed a willingness to improve but had not addressed core issues which could improve the quality and safety of the service; we found

Summary of findings

that they had not made sufficient improvements in the 18 months between publication of their report in 2015 and this inspection. Our key findings across all the areas we inspected in January 2017 are as follows:

- There was an open and transparent approach to safety but there was no effective system in place for reporting, recording and sharing significant events within the practice. The provider received safety alerts but did not have an effective system in place for ensuring that they were actioned.
- Risks to patients and other service users, such as those related to health and safety, immunisation of staff, handling of hazardous waste, blind cords in a waiting area, recruitment checks, and the availability of emergency medicines at both sites had not been assessed or well-managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance; however, there was no programme of quality improvement (for example clinical audits). Data from the Quality and Outcomes Framework (QOF) and other targets showed that the provider was a negative outlier for exception reporting for some health indicators when compared to local and national averages. They did not demonstrate any action plan in place to address performance in these areas.
- The provider was a positive outlier for QOF health indicators related to dementia, asthma, hypertension and chronic obstructive pulmonary disease and they had received an award from Public Health Bromley in May 2016 for achieving one of the highest Chlamydia screening rates in Bromley borough.
- There were no Patient Group Directions (PGDs) in place for two nurses who administered vaccines, and PGDs for another nurse had not been authorised in line with current legislation.
- The provider did not have an effective system in place for regularly monitoring patients taking disease-modifying antirheumatic medicines.
- The majority of staff were aware of their roles and responsibilities; however, we identified instances where some staff were not following the practice's policies.
- The provider had a number of policies and procedures to govern activity and held regular governance meetings; however, some policies needed to be updated.
- The majority of staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment; however, we were not provided with evidence of basic life support or fire safety training for a member of administrative staff.
- The provider had vicarious liability insurance in place for the practice, but did not provide us with evidence to demonstrate any medical indemnity insurance in place for a nurse; they addressed this shortly after the inspection.
- Results from the national GP patient survey showed that patients rated the service below average for several aspects of consultations with nurses and GPs. They were rated above average for several aspects of access to the service and satisfaction with receptionists.
- Information about services and how to complain was available and easy to understand, with the exception of avenues of carer support which were not advertised at the branch site. Carer identification was low. The provider made improvements to the quality of care as a result of complaints they received.
- Staff told us the provider did not offer interpreter services and they relied on staff and patients' family members to translate information at consultations. There was no hearing loop for patients with hearing difficulties.
- Although we observed that reception staff maintained patient and information confidentiality, conversations in the nurse's room at the main site could easily be overheard in the consulting room next to it.
- The provider had not appropriately documented various processes.
- The provider was experiencing a change in its leadership structure. At the time of our inspection there was no practice manager in place and we found that there were deficiencies in some of the provider's governance systems and processes. However, staff felt supported by the GP partners.

Summary of findings

There are areas where the provider needs to make improvements. Importantly, they must:

- Enable and support all service users to make, or participate in making, decisions relating to their care or treatment to the maximum extent possible. Specifically, improve accessibility for patients with language barriers.
- Ensure effective and sustainable clinical governance systems and processes are implemented to assess, monitor and improve the quality of the services provided, and implement an effective strategy to ensure the delivery of high quality care. This includes establishing a programme of audits including clinical audits, and implementing actions to improve patient satisfaction and outcomes for patients in relation to cervical screening and childhood immunisation. Additionally, ensure there are appropriate policies to enable staff to carry out their roles, practice policies are being followed, relevant records for persons employed are obtained, and all records pertaining to the running of the service are suitably maintained.
- Assess, mitigate and monitor risks to the health and safety of service users and others that may be at risk, Additionally, ensure the proper and safe management of medical equipment and medicines; this includes ensuring that medicines and equipment are available in sufficient quantities and are fit for use.

In addition the provider should:

- Review and improve how patients with caring responsibilities are identified and recorded on the clinical system to ensure that information, advice and support is made available to them.
- Review the need to improve accessibility for patients, particularly in relation to those with hearing difficulties.
- Ensure all staff are up to date with training.
- Improve patient privacy and confidentiality at the main site.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by the CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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.

- There was an open and transparent approach to safety but we found that there was an ineffective system in place for reporting, recording and sharing significant events within the practice.
- Risks to patients and other service users, such as those related to health and safety, blind cords in a waiting area, recruitment checks, and the availability of emergency medicines at both sites had not been assessed or well-managed. Furthermore, the provider did not have an effective system in place for ensuring that safety alerts were actioned or for regularly monitoring patients taking disease-modifying antirheumatic drugs. The provider conducted health and safety risk assessments after the inspection, and ensured blind cords were out of reach. They told us they had increased their supply of all emergency medicines but did not evidence this for two medicines.
- There were no Patient Group Directions (PGDs) in place for two nurses who administered vaccines, and PGDs for another nurse had not been authorised in line with current legislation (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a GP). The provider addressed this after our inspection.
- Non-clinical staff at the branch site told us they handled clinical waste, which was against the provider's policy, and the provider did not keep a record of their immunisation status to ensure that they were appropriately immunised against communicable diseases.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, a member of staff we spoke with was not clear on whom the practice's safeguarding lead was, the safeguarding children policy had not been updated with key practice-specific information and external contact, and two members of staff were not following the provider's chaperone policy.
- The provider had sought references but not conducted disclosure and barring service checks on two newly recruited staff prior to them commencing employment at the practice in

Summary of findings

line with their recruitment policy. They told us they had risk assessed this but did not provide us with any evidence of a risk assessment. We reviewed the curriculum vitae of a nurse and found that their employment history was not complete.

Are services effective?

Requires improvement

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

- Staff assessed patients' needs and delivered care in line with current evidence based guidance; however, data from the Quality and Outcomes Framework (QOF) showed that the provider was a negative outlier for exception reporting for health indicators related to diabetes, atrial fibrillation and mental health when compared to local and national averages. They were also performing below average for cervical screening and administering childhood vaccinations. The provider told us they were following local guidelines but did not demonstrate any action plan in place to address performance in all of these areas.
- Data showed that the provider was a positive outlier for QOF health indicators related to dementia, asthma, hypertension and chronic obstructive pulmonary disease.
- Although three clinical audits had been conducted, none of them were completed two-cycle audits. We saw limited evidence to demonstrate that audits were driving improvements to patient outcomes.
- The majority of staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment; however, we were not provided with evidence of basic life support or fire safety awareness training for a member of administrative staff.
- There was evidence of appraisals and personal development plans for the majority of staff, and others were due shortly after our inspection.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The provider received an award from Public Health Bromley in May 2016 for achieving one of the highest Chlamydia screening rates in Bromley borough.

Are services caring?

Requires improvement

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

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- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment, but data from the national GP patient survey published in July 2016 showed that patients rated the practice below others for several aspects of consultations with GPs and nurses.
- Information for patients about the services available was easy to understand and accessible with the exception of avenues of carer support which were not advertised at the branch site. The provider had engaged with Bromley Carers to improve identification of carers but had only identified 0.4% of their patient population as carers, which was low.
- During the inspection we saw staff treat patients with kindness and respect. Although staff maintained patient and information confidentiality, conversations in the nurse's room at the main site could easily be overheard in the consulting room next to it.
- The provider told us they did not provide interpreter services for patients that did not speak or understand English as their first language.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Appointments were not available on Wednesday afternoons at either the main or branch site. The practice offered daily telephone appointments, and extended hours appointments were available from 6.30pm to 8pm on Monday evenings at the main site.
- 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. This was reflected in results from the national GP patient survey published in July 2016 where the provider was rated above average for several aspects of access to the service, and satisfaction with receptionist staff was high.
- There were no baby changing facilities at the branch site and no hearing loop at either site for patients that were hard of hearing. Staff told us they did not offer an interpreter service for patients that could not speak or understand English.
- The practice offered a range of online services such as appointment booking and repeat prescription ordering to facilitate access to the service for patients.

Summary of findings

- Information about how to complain was available and was easy to understand. Our review of the provider's complaints showed that they responded in a timely manner and with transparency to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Inadequate

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

- The provider expressed a willingness to improve but they did not have an effective system in place for identifying, monitoring and managing risks, recording and sharing serious incidents within the practice, or improving quality.
- The provider had a vision and strategy to deliver high quality care and promote good outcomes for patients; however, they did not demonstrate this during the inspection. We found that there were deficiencies in several of the provider's governance systems and processes. Some issues were repeated and had not improved since our last inspection.
- The majority of staff were aware of their roles and responsibilities; however, a chaperone and a GP partner were not following the provider's chaperone policy and non-clinical staff that told us they handled clinical waste against the provider's waste management policy. A member of staff was not clear on who the safeguarding lead was. Another was not aware of the business continuity plan and its use, or of the location of the emergency medicines.
- The provider had a number of policies and procedures to govern activity and held regular governance meetings. The safeguarding children policy needed to be updated with practice-specific information and external contacts, and the policy for handling serious incidents also needed to be updated.
- The provider need to improve documentation of various processes, for example, there were no records of an induction completed for a new nurse, actions completed from risk assessment action plans, and actions taken in response to abnormal fridge temperature recordings.
- The provider was aware of feedback from the national GP patient survey results published in July 2016 but had not implemented any plans at the time of our inspection to improve the service and patient satisfaction where they were below average.
- The provider was aware of their responsibilities in relation to the duty of candour.

Summary of findings

- The provider was experiencing a change in its leadership structure. At the time of our inspection there was no practice manager in place. Staff felt supported by the GPs.

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 the care of older people. They were rated as requires improvement for being safe, effective and caring, and as inadequate for being well-led. The issues identified as requires improvement overall affected this population group.

- The provider offered proactive, personalised care to meet the needs of the older people in its population.
- The provider was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- All patients aged over 75 years had a named GP to ensure continuity of care.
- We spoke with the manager of a local care home who told us they were very satisfied with the care provided to the home's residents by the practice's GPs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. They were rated as requires improvement for being safe, effective and caring, and as inadequate for being well-led. The issues identified as requires improvement overall affected this population group.

- Nationally reported data for 2015/2016 showed that outcomes for patients with diabetes and atrial fibrillation were generally above average, but exception reporting was higher than the local Clinical Commissioning Group (CCG) and national average for some indicators. For example:
  - 76% of patients with diabetes had well-controlled blood sugar in the previous 12 months (CCG average 77%, national average 78%). Exception reporting for this indicator was 18% which was above the CCG average of 8% and the national average of 13%.
  - 96% of patients with atrial fibrillation were treated with anti-clotting therapy (CCG average 86%, national average 87%). Exception reporting for this indicator was 24% which was above the CCG average of 11% and the national average of 10%.

Summary of findings

- Outcomes for other long-term conditions were above local and national averages. All patients with a long-term condition had a named GP and the majority had received a structured annual review to check their health and medicines needs were being met. For example:
  - In the previous 12 months, 96% of patients with asthma had an asthma review (CCG average 73% and the national average 76%).
  - In the previous 12 months, 97% of patients with chronic obstructive pulmonary disease had a review of their condition (CCG average 89%, national average 90%).
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- 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.
- Longer appointments and home visits were available when needed.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. They were rated as requires improvement for being safe, effective and caring, and as inadequate for being well-led. The issues identified as requires improvement overall affected this population group.

- In the previous 12 months, 74% of women aged between 25 to 64 years had a cervical screening test. This was below the local average of 82% and the national average of 81%. Exception reporting for this indicator was 8%, which was higher than the local average of 4% and the national average of 7%.
- Immunisation rates were below local and national averages for some standard childhood immunisations.
- The provider received an award from Public Health Bromley in May 2016 for achieving one of the highest Chlamydia screening rates in Bromley borough.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. However, there were no baby changing facilities at the branch site.
- Appointments were available outside of school hours on Monday evenings until 8pm.

Summary of findings

- The practice engaged in joint working with midwives and health visitors. They had systems in place to identify and follow up children living in disadvantaged circumstances and those at risk; for example, children and young people who had a high number of attendances to Accident & Emergency services.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). They were rated as requires improvement for being safe, effective and caring, and as inadequate for being well-led. The issues identified as requires improvement overall affected this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Extended hours opening was available on Monday evenings from 6.30pm to 8pm at the main site, for patients that were not able to attend during normal opening hours.
- There were no appointments available on Wednesday afternoons at either the main site or branch site, but patients we spoke with said they were able to get appointments when needed. This was reflected in results from the national GP patient survey published in July 2016.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. They were rated as requires improvement for being safe, effective and caring, and as inadequate for being well-led. The issues identified as requires improvement overall affected this population group.

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- Out of 32 patients registered with a learning disability, 25 (78%) had received an annual review of their care.
- The practice offered longer appointments for patients with a learning disability and regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). They were rated as requires improvement for being safe, effective and caring, and as inadequate for being well-led. The issues identified as requires improvement overall affected this population group.

- In the previous 12 months, 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan in their record. This was above the local average of 83% and the national average of 89%. However, exception reporting for this indicator was 17% which was above the local Clinical Commissioning Group average of 7% and the national average of 10% (exception reporting is the removal of patients where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- In the previous 12 months, 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting, which was above the CCG average of 82% and the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia, and they had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended Accident and Emergency where they may have been experiencing poor mental health.
- Staff we spoke with 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 published in July 2016 showed the practice was performing below local clinical commission group (CCG) and national averages for several aspects of consultations with GPs and nurses, but they were rated above average for experiences with reception staff and access to care. Of 277 survey forms distributed, 111 were returned. This represented approximately 3% of the practice's patient list.

- 97% of patients found it easy to get through to this practice by phone (CCG average 70%, national average 73%).
- 95% said they found the receptionists at the practice helpful (CCG average 86%, national average of 87%).
- 93% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 74%, national average 76%).
- 79% of patients described the overall experience of this GP practice as good (CCG average 83%, national average 85%).
- 68% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 77%, national average 80%).
- 74% said the GP was good at listening to them (CCG average 88%, national average 89%).
- 78% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 91%).

As part of our inspection we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all positive about the standard of care received. Patients commented that they found staff to be helpful, caring and professional.

We spoke with a patient prior to the inspection and seven patients during the inspection. These patients said they were generally satisfied with the care they received and thought staff members were approachable and caring. However, some of them indicated that they did not always feel involved with their treatment and the risks or side-effects of medicines had not always been explained.

We spoke with the manager of a local care home who told us they were very satisfied with the care provided to the home's residents by the practice's GPs.

Results from the practice's December 2016 NHS Friends and Family Test showed that 100% of the six patients surveyed (approximately 0.2% of the practice's patient list) were likely or extremely likely to recommend the practice.

Highland Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission lead inspector**.** The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Highland Medical Practice

Highland Medical Practice operates from two sites. The main site is based at 10 Highland Road, Bromley, Kent, BR1 4AD and the branch site is based at 7A/B Tubbenden Lane, Orpington, Kent, BR6 9PN. It is one of 48 GP practices in the Bromley Clinical Commissioning Group (CCG) area. There are approximately 3,800 patients registered at the practice. This includes patients that reside at a local care home.

The practice was previously registered with the Care Quality Commission (CQC) as Dr Gnanachelvan & Partners; they changed their name to Highland Medical Practice in December 2016. The practice is registered with the CQC to provide the regulated activities of:

- Diagnostic and screening procedures.
- Family planning services.
- Maternity and midwifery services.
- Surgical procedures.
- Treatment of disease, disorder or injury.

The practice has a personal medical services contract with the NHS and is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These enhanced services include:

- Childhood immunisation and vaccination.
- Dementia.
- Extended hours.
- Influenza and pneumococcal immunisation.
- Patient participation.
- Rotavirus and shingles immunisation.
- Unplanned admissions.

The practice has an above average population of female patients aged from 75 to 79 and 85+ years, and an above average population of male patients aged from 35 to 85+ years when compared to the national average. Income deprivation levels affecting children and adults registered at the practice are similar to the Bromley CCG average and below the national average.

The clinical team includes two male GP partners (one of whom is a member of Bromley's Local Medical Committee), a female GP partner and a female long-term locum GP. The GPs provide a combined total of 18 fixed sessions per week. There are three female practice nurses (one of whom is qualified as a nurse practitioner) and a female health care assistant. The clinical team is supported by an operations support manager and seven administrative/reception staff.

The practice's main and branch sites are open from 8am to 6.30pm from Monday, Tuesday, Thursday and Friday. Both sites close at weekends and bank holidays, and at 1pm on Wednesdays. Appointments (including extended hours) are available at the following times:

Detailed findings

Monday: 9am-11am, 3.30pm-4.30pm (last appointment at the branch site is at 5pm), 5.30pm-8pm (late opening applies to the main site only).

Tuesday: 9am-11.30am, 3.15pm-5pm.at

Wednesday: 9am-12pm.

Thursday: 9am-11am, 3pm-5pm.

Friday: 9am-12.30pm, 3.30pm-5pm.

The provider told us that although appointments are not available on Wednesday afternoons, the reception office remains open at the main site for patients to book appointments and drop off repeat prescription requests.

The main site operates over the ground and first floors of a converted house. There are three consulting rooms, a treatment room, a waiting area, a reception office, and an accessible patient toilet with baby changing facilities. There is wheelchair access throughout the ground floor although we observed that there is a small step at the main entrance. There is no allocated disabled parking but the patients are able to park outside the practice on Highland Road at any time between 12pm and 2pm.

The branch site operates over the ground and first floors of a converted house. There is a consulting room, a treatment room, a patient toilet, a waiting area and a reception office. There is no wheelchair access. There are three car parking spaces available.

The practice directs patients needing urgent care outside of normal hours to contact the out-of-hours (OOH) number 111, which directs patients to a local contracted OOH service or Accident and Emergency, depending on the urgency of the medical concern.

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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 10 January 2017. During our visit we:

- Spoke with a range of staff including two GP partners, the operations supporting manager, two administrative/ reception staff and a practice nurse.
- Spoke with seven patients who used the service (we also spoke with a patient prior to the inspection).
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed 34 comment cards where patients and members of the public shared their views and experiences of the service.

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

Detailed findings

- 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 the last announced comprehensive inspection on 10 February 2015 we found that the provider did not demonstrate safe care, as there were deficiencies in their processes. The provider sent us an action plan stating that they would implement the necessary improvements by December 2015.

We found that the provider had made limited improvements when we undertook this announced comprehensive inspection on 10 January 2017, and the provider remains rated as requires improvement for providing safe services.

Safe track record and learning

At the last inspection on 10 February 2015 we found that the provider kept records of significant events and discussed them with staff. However, significant events had not been documented in meeting minutes, or included as a permanent item on meeting agendas. An incident involving a problem with the vaccines fridge had been reported to the clinical commissioning group (CCG) but had not been documented within the practice.

During this inspection we found that the practice did not have an effective system in place for reporting and recording significant events, or for ensuring that safety alerts received by the practice were actioned.

- A practice nurse we spoke with informed us of a serious incident involving a vaccine administration error; however, they were not sure whether this incident had been documented and did not demonstrate a clear understanding of the practice's process for handling significant events. We reviewed the practice's significant event folder and found that there was no record of documentation of this incident. Although the nurse told us the incident had been discussed at a meeting, we reviewed the provider's meeting minutes and were unable to find any record of this. The provider told us after the inspection that the vaccine administration error had not been brought to their attention when it occurred.
- A GP partner told us the practice used their complaints form to record serious incidents and significant events. They told us the practice did not have a serious incident or significant event recording form. A practice nurse, a GP partner and a receptionist we spoke with were not aware of any incident recording form; a GP partner created one from a predefined template during the inspection. The new 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).
- During the inspection, the provider was not able to provide us with any evidence of significant events that the practice had recorded using either their complaint form or a significant event recording form. Prior to our inspection the provider informed us of two significant events that had occurred in the previous 12 months; we reviewed meeting minutes and found that these had been analysed and discussed with clinical staff. A non-clinical member of staff we spoke with at the branch site could not recall any significant events that had been discussed in the practice.
- The provider's policy for handling serious incidents was generic and had not been amended to be practice-specific. For example, it referred to 'the practice manager' but there was none in place at the time of our inspection, and it referred to 'the senior partner' but did not state who this was. It included guidance for escalating complaints but did not include the process for recording incidents. Some staff told us they would inform a GP partner of any incidents or record them in the practice's messaging book, and another said they would report them to the practice manager.
- We reviewed two safety alerts received by the practice, on the contraindications of sodium valproate in pregnancy and the interaction of spironolactone and angiotensin-converting-enzyme inhibitors. We found that one of the GP partners was not aware of these alerts and the practice had not taken any steps to action them, for example by running searches on their computer system to identify any patients that may have been affected (sodium valproate is used to treat epilepsy, migraines and bipolar disorder, spironolactone is a particular type of diuretic (water) tablet). The provider was, however, able to demonstrate an instance where they had reported a safety incident externally to the local CCG regarding an error with a patient's blood test results; this had been recorded as a complaint but not as a significant event. Another incident involving a

communication error leading to a suspected misdiagnosis had been raised with external organisations but had also not been recorded as a significant event.

Overview of safety systems and processes

At the last inspection on 10 February 2017 we found that not all staff members were aware of their responsibilities and the process to follow under the provider's child protection policy. There was no evidence to demonstrate that any staff had received safeguarding training. Notices had not been displayed to inform patients that chaperones were available if needed. There was a lack of clarity between staff over who acted as chaperones. Staff who told us they acted as chaperones had received a briefing for their role but had not undergone 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).

During this inspection, we found that the practice had systems in place to keep patients safe, and safeguarded from abuse; however we identified areas that required improvement.

- Arrangements were in place to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. Safeguarding policies were accessible to all staff. The policies clearly outlined the practice's lead contact from whom guidance should be sought if staff had concerns about a patient's welfare. The safeguarding children policy referred to the practice's deputy safeguarding lead but did not state who this was, and staff told us during the inspection that there was no deputy in place. The policy also referred to the local authority children's referral and assessment team but did not include contact details of named leads within the borough. There was a lead member of staff for safeguarding; however, one of the members of staff we spoke with did not correctly identify this individual. After the inspection the provider told us that they displayed posters in every room indicating details of the practice's safeguarding lead and local details; however, they did not demonstrate that the safeguarding children policy had been updated. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three, nurses were trained to level three and non-clinical staff were trained to level one.
- The practice offered patients chaperones; however, staff we spoke with were not following the practice's chaperone policy. A GP partner told us chaperones were instructed to stand outside of the privacy curtain and that they did not document in the patients' record that a chaperone was present or when patients declined a chaperone, both of which were not in line with the practice's chaperone policy. A chaperone told us they would stand outside of the curtain. A notice in the waiting room advised patients that they were available if required. All staff who acted as chaperones had been trained for the role and had received a 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). After the inspection the provider told us they had reiterated the chaperone procedure to all staff members.

At the last inspection 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. There was no system in place to indicate when privacy curtains should be replaced. The provider could not demonstrate that several staff members had received infection control and prevention training, and they did not have records of the immunisation status of several clinical staff to demonstrate that they had been immunised against communicable diseases.

During this inspection we found that the provider had addressed some of these issues but there were still areas that required improvement:

- We observed the premises to be clean and tidy. A GP partner was the infection control 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 and staff had received up to date training. Annual infection control audits were undertaken. We saw evidence that although some

action had been taken to address improvements identified from an infection control audit conducted on 5 January 2017; these actions had not been documented.

- There was a lack of clarity over which staff should dispose of clinical waste bins and sharps boxes (used to store used sharp instruments such as needles); non-clinical staff at the branch site told us they undertook this task but a GP partner said that the practice's protocol was for the cleaner or clinical staff only to manage clinical waste. They sent us evidence of the immunity status of the cleaner after the inspection but told us they did not have records to demonstrate that non-clinical staff at the branch site had been appropriately immunised. After the inspection, the provider told us they had risk assessed taff that handled clinical waste and those at clinical risk, but they did not send us any evidence to demonstrate this.

At the last inspection we found that the provider did not have a system in place to monitor the use of prescription pads kept in doctor's bags. We found two expired tubes of lubrication gel had been disposed of in a domestic waste bin instead of a clinical waste bin. The provider had adopted Patient Group Directions (PGDs) for practice nurses to allow them to administer medicines; however, there was no documentation of this on site (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a GP). A medicines management policy had not been updated since 2007 and needed to be reviewed.

During this inspection we found:

- The arrangements for managing medicines in the practice, including vaccines, required improvement. There was no system in place to prevent the power supply to the vaccines fridge at the main site from being accidentally interrupted; however, shortly after our inspection the practice installed a cover for the fridge plug with clear instructions not to disconnect the plug. At the branch site, we reviewed vaccine fridge temperature logs and found that there was no record of any action taken when the fridge temperature exceeded the maximum recommended; we discussed this with receptionists who informed us of appropriate action they had taken. After the inspection the provider told us they had taken steps to ensure that actions taken in response abnormal fridge temperatures were recorded; they did not provide any evidence to support this. The vaccines fridges at both sites did not have an additional back-up thermometer to provide a means of cross-checking the accuracy of the temperatures.
- The provider was not able to demonstrate that they had an effective system in place for recalling patients taking disease-modifying antirheumatic drugs.
- We requested PGDs for all practice nurses that administered vaccines but the provider only provided us with PGDs for one nurse. The provider ensured that PGDs were in place and authorised for all of the practice nurses shortly after our inspection.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. 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 and pads were securely stored and there were systems in place to monitor their use.

At the last inspection the provider was not able to provide documented evidence of interview and selection decisions, and there was no evidence that pre-employment checks had been conducted for a new member of staff. They were also not able to demonstrate that they had sought information from locum agencies that locum clinical staff had undergone suitable background checks, or that they were suitably qualified, skilled and experienced.

During this inspection we found that there remained deficiencies in the provider's recruitment processes:

- We reviewed two personnel files for staff that had been recruited within the last 12 months and found that although there was a curriculum vitae in place for a nurse, it did not contain the nurse's full employment history and only dated back to 2010. The practice had not conducted a DBS check for this nurse until 11 months after they commenced employment at the practice, neither had they conducted one for a receptionist until a week after starting work at the practice (the practice's recruitment policy stated that DBS checks should be sought prior to commencing employment). A GP partner told us that they had obtained a DBS check from the nurse's previous place of

employment and subsequently carried out a new DBS check after risk assessing that it was needed. They did not provide us with any documentation of this risk assessment. The provider had sought references for staff as part of their recruitment procedure.

- The practice's recruitment policy stated that an interview proforma should be completed for interview candidates, but we found that there was no evidence of a proforma completed for a recently recruited receptionist.
- There was no evidence of suitable medical indemnity cover in place for a nurse but the practice ensured that this was in place shortly after our inspection. The provider told us they had vicarious liability in place, which they claimed would have provided suitable cover prior to obtaining indemnity cover for the nurse.

Monitoring risks to patients

At the last inspection on 10 February 2015 we found that the provider had not conducted a health and safety risk assessment, or assessments of the risk of fire or Legionella infection. They told us they conducted visual inspections of the premises and equipment but this was not documented. Single-use instruments such as an un-pouched speculum had not been disposed of as required and had been left in a training room.

During this inspection we found that risks to patients continued not to be well assessed or well managed.

- The practice had not conducted a health and safety risk assessment for the main or branch sites but one was conducted for each site after our inspection. They had a variety of other risk assessments in place to monitor safety of the premises such as the control of substances hazardous to health, infection control, and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- We observed that domestic cleaning solutions including the hazardous chemical sodium hypochlorite (more commonly known as bleach) were stored in an unlocked kitchen on the ground floor at the branch site, and were therefore not secure.
- There was a health and safety policy available with a poster in the reception office at the main site, but there was no health and safety poster displayed at the branch site.
- There were no fire action plans on the premises at the main site to indicate action to take in the event of a fire but the practice ensured that these were in place shortly after our inspection. The practice had conducted a fire risk assessment in August 2016; issues identified as requiring action had been completed but not documented. The provider carried out regular fire drills; however, staff at the branch site told us the drills at the branch site were not documented. After the inspection, the provider sent us evidence of a fire evacuation drill conducted at the branch site dated November 2016.
- All electrical equipment had been checked by a contractor to ensure it was safe to use and clinical equipment was checked to ensure it was working properly; these checks were conducted in January 2016, and electrical checks were repeated after our inspection in January 2017.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

Arrangements to deal with emergencies and major incidents

At the last inspection the provider had emergency equipment but their checks of this equipment had not been documented, and there were no records to demonstrate that clinical staff had completed basic life support training. The provider's business continuity plan had been recently reviewed but contained outdated information of organisations that no longer existed. The provider was not able to demonstrate that staff had completed fire safety training, and they had not conducted regular checks of the fire alarm to ensure it was in good working order. There was no evidence to show that fire evacuation drills had been conducted.

During this inspection, the provider had arrangements in place to respond to emergencies and major incidents, but there were still areas that required improvement:

- The provider did not stock the emergency medicine Diazepam (used to treat epilepsy) at the main and branch sites. They also did not stock Glucagon or Glucagel (used to treat diabetic episodes), salbutamol (used to treat asthma) or glycerol trinitrate (used to treat angina) at the branch site and they had not formally assessed the associated risks. Aspirin (used to treat suspected heart attack) at the branch site was not

dispersible which was not in line with guidelines. The provider ensured that Diazepam was available at both sites, and that glucagon and dispersible aspirin was available at the branch site shortly after the inspection. They also told us after the inspection that glycerol trinitrate and salbutamol were available but did not provide any evidence of this. Other emergency medicines were easily accessible to staff in a secure area of the practice; the majority of staff we spoke with knew of their location but one non-clinical staff member told us they were not sure where the emergency medicines were kept.

- All the medicines and equipment we checked at the main site were in date and stored securely; however, we found that some injection needles at the branch site had expired on dates between 2003 and 2010.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- There was evidence to demonstrate that all staff, except a non-clinical member of staff, had received annual basic life support training. There was also no evidence of fire safety training for this staff member. The provider sent us a training log for this individual prior to the inspection; the log indicated that they had received fire safety training within the last three years (it did not specify any dates), but they did not send us any proof of this. The log did not indicate that they had received basic life support training.
- The practice had a defibrillator available on both premises and oxygen with adult and children's masks; however, there were no systems in place at either site to regularly log the condition of this equipment. A first aid kit and accident book were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage; a member of staff we spoke with was not aware of the plan or its use. The plan included emergency contact numbers for staff and a copy of it was kept off-site by a GP partner.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At the last announced comprehensive inspection on 10 February 2015 we found that the provider did not demonstrate effective care, as there were deficiencies in their processes. The provider sent us an action plan stating that they would implement the necessary improvements by December 2015.

We found that the provider had made limited improvements when we undertook this announced comprehensive inspection on 10 January 2017, and the provider remains rated as requires improvement for providing effective services.

Effective needs assessment

At the last inspection on 10 February 2015 and during this inspection, we found that the provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

At this inspection the provider had systems in place 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.

Management, monitoring and improving outcomes for people

At the last inspection on 10 February 2015 the provider had systems in place to manage monitor and improve outcomes for people. This included a programme of clinical audits, and they had met targets for several performance targets in relation to the Quality and Outcomes Framework (QOF). QOF is a system intended to improve the quality of general practice and reward good practice. The provider was below average for outcomes relating to the management of patients with chronic kidney disease (this indicator is no longer included in QOF).

During this inspection, we found that the provider used information collected for QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results were 97.9% of the total number of points available; this was in line with the local Clinical Commissioning Group (CCG) average of 95.4% and the national average of 94.8%. The practice's overall clinical exception reporting rate was 13.3%, which was above the CCG average 8.2% and the national average of 9.8% (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 a negative outlier for some QOF clinical targets in relation to exception reporting, but it was a positive outlier for targets relating to dementia, hypertension, asthma and chronic obstructive pulmonary disease (COPD). Data from 2015/2016 showed that in the previous 12 months:

- Performance for diabetes related indicators was generally above average, but exception reporting was higher than average for several indicators. For example, of patients recorded as having diabetes:
  - 76% had well-controlled blood sugar (CCG average 77%, national average 78%). Exception reporting for this indicator was 18% which was above the CCG average of 8% and the national average of 13%.
  - 87% had well-controlled cholesterol (CCG average 77%, national average 80%). Exception reporting for this indicator was 21% which was above the CCG average of 10% and the national average of 13%.
  - 97% had well-controlled blood pressure (CCG average 75%, national average 78%). Exception reporting for this indicator was 10% which was slightly above the CCG average of 7% and in line with the national average of 9%.
- Performance for indicators related to atrial fibrillation was above average, but exception reporting was higher than average. For example, 96% of patients with atrial fibrillation were treated with anti-clotting therapy (CCG average 86%, national average 87%). Exception reporting for this indicator was 24% which was above the CCG average of 11% and the national average of 10%.
- Performance for mental health related indicators was above average, but exception reporting was higher than average. For example, of patients recorded as having schizophrenia, bipolar affective disorder, and other psychoses:

Requires improvement

Are services effective?

(for example, treatment is effective)

  - 100% had a comprehensive, agreed care plan in their record (CCG average 83%, national average 89%). Exception reporting for this indicator was 22% which was above the CCG average of 8% and the national average of 13%.
  - 100% had a record of their alcohol consumption (CCG average 83%, national average 89%). Exception reporting for this indicator was 17% which was above the CCG average of 7% and the national average of 10%.

- Performance for dementia related indicators was above average, and exception reporting was below average. For example, 100% of patients with dementia had a face-to-face review of their care (CCG average 82%, national average 84%). Exception reporting for this indicator was 0%, which was below the CCG average of 5% and the national average of 7%.
- Performance for hypertension related indicators was above average, and exception reporting was average. For example, 95% of patients with hypertension had well-controlled blood pressure (CCG average 80%, national average 83%). Exception reporting for this indicator was 4%, which was in line with the CCG average of 3% and the national average of 4%.
- Performance for asthma related indicators was above average, and exception reporting was below average. For example, of patients recorded as having asthma, 96% had a review of their condition (CCG average 73%, national average 76%). Exception reporting for this indicator was 4%, which was below the CCG average of 7% and the national average of 8%.
- Performance for indicators related to COPD was above average, and exception reporting was below average. For example, 97% of patients with COPD had a review of their condition (CCG average 89%, national average 90%). Exception reporting for this indicator was 6%, which was below the CCG average of 10% and the national average of 12%.
- The provider had been given an award in May 2016 from Public Health Bromley for achieving one of the highest rates of chlamydia testing in the borough of Bromley.

We raised these results with two GP partners. One of them informed us that the practice was following local guidelines in automatically exception reporting patients after sending three appointment invitation letters. They also said that they offered patients opportunistic testing when patients attended for other consultations. Another GP partner told us that the practice had a low prevalence of patients with diabetes (approximately 6% of the practice's population were registered as having diabetes), and that there had been poor compliance from these patients. Neither of the GP partners discussed any actions the practice was taking to address the issues we highlighted in relation to higher than average exception reporting.

Following the inspection, a GP partner informed us that in an effort to improve outcomes for patients with diabetes they had up-skilled practice GPs in February 2017, after our inspection, so that they could offer insulin initiation in-house instead of referring patients to other services (insulin initiation is provided to patients that are newly diagnosed with diabetes to improve control of the condition and prevent it from progressing). They also told us that they included telephone calls to patients before exception reporting them.

In relation to areas of performance that were above average, a GP partner informed us that they had applied for an investment grant from the local Clinical Commissioning Group in 2015 to improve outcomes for patients with dementia. They told us they ran a search to identify all patients with asthma on their register, and contacted as many of them as possible to attend for screening. The GP partner also told us that the practice had been more proactively focused on improving care for patients with COPD, for example by offering more spirometry testing in-house via their specialist nurse, and that they had streamlined their care of patients with long-term conditions to nursing staff and the health care assistant.

We found that there was limited evidence to demonstrate that clinical audits were driving improvement to patient outcomes, as the provider had not established a programme of quality improvements (including clinical audits).

- There had been three clinical audits completed in the previous two years, none of which were completed two cycle audits. Although the practice had identified improvements needed through the audits, these improvements had not been implemented or monitored.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice participated in local audits with the Clinical Commissioning Group, external peer review, and local and national benchmarking.

Effective staffing

At the last inspection on 10 February 2015 we found that the provider had not conducted appraisals for all staff to monitor their progress and development needs. There were gaps in training for several staff; this training included basic life support, infection control, fire safety awareness, and safeguarding children. Staff inductions had not been documented.

During this inspection we found that:

- The practice had an induction programme for all newly appointed staff. This covered topics such infection control awareness, fire procedures, health and safety, security and complaints, and other information contained within the employee handbook. We reviewed 14 staff files and found that there was no record of induction completed for a recently recruited practice nurse.
- 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, and those conducting cervical cytology screening had received specific training.
- Staff who administered vaccines had received appropriate training, and they could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and attendance to update courses. However, the provider had not ensured that two nurses had been given the proper legal authorisation to administer vaccines.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. We found that the majority of staff had received an appraisal within the last 12 months, and others were due an appraisal shortly after our inspection.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included e-learning training modules, in-house and external training, ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs.
- We found that the majority of staff had received training that included safeguarding, fire safety awareness, basic life support and information governance. However, we were not provided with evidence of basic life support and fire safety awareness training for a member of administrative staff. The provider sent us a training log for this individual prior to the inspection; the log indicated that they had received fire safety training within the last three years (it did not specify any dates), but they did not send us any proof of this. The log did not indicate that they had received basic life support training.

Coordinating patient care and information sharing

At the last inspection on 10 February 2015 we found that the practice ensured a joined-up approach with external professionals to meet patients' needs.

During this inspection we found that 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.
- 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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

At the last inspection on 10 February 2015 we found that staff sought patients' consent to care and treatment in line with legislation and guidance.

During this inspection:

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Requires improvement

Are services effective?

(for example, treatment is effective)

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.

Supporting patients to live healthier lives

At the last inspection on 10 February 2015 and at this inspection we found that the provider had systems in place to support patients to live healthier living. For example:

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The health care assistant gave patients basic lifestyle advice. Patients requiring more enhanced support from a dietician were referred to local support groups.
- The nurse provided smoking cessation advice to patients that required it.

At the last inspection uptake for cervical screening was 9.4% below the national average. This had not improved at the time of this inspection; the practice's uptake for the cervical screening programme was 74%, which was below the local clinical commissioning group (CCG) average of 82% and the national average of 81%. Exception reporting for this indicator was 8%, which was above the CCG average of 4% and in line with the national average of 7%). We raised these results with the GP partners, one of whom informed us that they had identified this as an area that needed to be improved. Another partner told us the practice had experienced poor compliance with screening attendance from patients.

- There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.
- There were systems in place 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 ensured a female sample taker was available.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- In the previous three years, 71% of females aged 50 to 70 were screened for breast cancer; this was in line with the CCG average of 75% and the national average of 73%.
- In the previous two and a half years, 46% of patients were screened for bowel cancer; this was below the CCG average of 57% and the national average of 58%.

At the last inspection, childhood immunisation rates were in line with the national average. During this inspection, published data showed that childhood immunisation rates for the vaccines given to children aged below two years were below average. There are four areas where immunisations for children of this age group are measured; each has a target of 90%. The practice did not meet the target in four out of four areas. These measures can be aggregated and scored out of 10, with the practice scoring 8.2 (compared to the national average of 9.1).

- 85% of children aged 1 year had received the full course of recommended vaccines (expected standard 90%).
- 84% of children aged two years had received the pneumococcal conjugate booster vaccine (expected standard 90%).
- 80% of children aged two years had received the haemophilus influenzae type b and meningitis C booster vaccine (expected standard 90%).
- 80% of children aged two years had received the measles, mumps and rubella (MMR) vaccine (expected standard 90%).

The childhood immunisation rate for the vaccinations given to children aged under five years was in line with local and national averages for one indicator, but was below the national average for another:

- 96% of children aged five years had received the MMR dose 1 vaccine (CCG average 95%, national average 94%).
- 80% of children aged five years had received the MMR dose 2 vaccine (CCG average 85%, national average 88%).

Requires improvement

Are services effective?

(for example, treatment is effective)

We raised these results with a GP partner who informed us they were aware that improvements were needed in this area, and that they planned to review their recall system.

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.

Requires improvement

Are services caring?

Our findings

At the last announced comprehensive inspection on 10 February 2015 the provider was rated as good for providing caring services.

We found deficiencies in the provider's processes when we undertook this announced comprehensive inspection on 10 January 2017, and the provider is now rated as requires improvement for this key question.

Kindness, dignity, respect and compassion

At the last inspection on 10 February 2015 patients told us they were treated with compassion. Results from the national GP patient survey showed that patients rated practice clinicians below average for listening to them during consultations.

During this inspection, we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. Patients gave us positive feedback but the practice was rated below average for several aspects of consultations with clinicians.

- Cabinets used to store patients' medical records at the branch site were not locked. Staff told us that they locked the main entry door to the areas containing the cabinets at the end of each day.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consulting and treatment room doors were closed during consultations, but conversations taking place in the room being used by the nurse could easily be overheard in the consulting room next to it.
- 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.

We received and reviewed 34 Care Quality Commission patient comment cards and found that all of them contained positive feedback about the service experienced. Comments highlighted that staff responded compassionately when they needed help and provided support when required. Patients also commented that they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We spoke with eight patients including a member of the practice's patient participation group. They told us they were generally satisfied with the care provided by the practice but some highlighted that they did not always feel involved in their care and treatment, and that the side effects and risks of medicines had not always been explained to them.

The national GP patient survey was published in July 2016. The results showed that although the majority of patients felt they were treated with compassion, dignity and respect, patients scored the practice below several local clinical commissioning group (CCG) and national averages for consultations with GPs and nurses. However, they were rated above average for the helpfulness of receptionists. Out of 111 of the practice's patients surveyed:

- 74% said the last GP they saw or spoke to was good at listening to them (CCG average 88%, national average 89%).
- 73% said the last GP they saw or spoke to gave them enough time (CCG average 85%, national average 87%).
- 77% said the last GP they saw or spoke to was good at treating them with care and concern (CCG average 83%, national average 85%).
- 85% said they had confidence and trust in the last GP they saw or spoke to (CCG average 92%, national average 92%).
- 80% said the last nurse they saw or spoke to was good at listening to them (CCG average 91%, national average 91%).
- 81% said the last nurse they saw or spoke to gave them enough time (CCG average 92%, national average 92%).
- 78% said the last nurse they saw or spoke to was good at treating them with care and concern (CCG average 91%, national average 91%).
- 94% said they had confidence and trust in the last nurse they saw or spoke to (CCG average 97%, national average 97%).
- 95% said they found the receptionists at the practice helpful (CCG average 86%, national average of 87%).
- 79% described their overall experience of the service as good (CCG average 83%, national average 85%).

- 68% said they would recommend the practice to someone who had just moved to the area (CCG average 77%, national average 80%).

We raised these results with a GP partner. They said that they felt these results were not representative of their patient demographic such as older patients and those who could not speak or understand English; however, the provider did not demonstrate any action they had taken to support this view. They also told us they recognised the practice needed to strengthen their engagement with patients and involving them in their treatment, and that they had recently implemented a practice slogan "at the heart of patient-centred care". After our inspection they told us they had begun the process of requesting training from their local clinical commissioning group for staff, to improve the patient experience. The provider's December NHS friends and family test showed that out of six patients surveyed (approximately 0.2% of the practice's patient list), 100% would recommend the practice.

Care planning and involvement in decisions about care and treatment

At the last inspection on 10 February 2015 patients told us they felt involved in their care and said clinicians explained things to them adequately. They had access to an interpreter service for patients who needed it.

During this inspection patients rated the provider below local and national averages in the national GP patient survey for listening to them and involving them in their care. Some of the eight patients we spoke with told us they did not always feel involved in decision making about the care and treatment they received, and that side effects and risks of medicines had not always been explained to them. However, they 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. Feedback from the 34 comment cards we received was positive in this regard. We saw that care plans were personalised.

The national GP patient survey was published in July 2016. Results showed that although the majority of patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, patients scored the practice below local clinical commissioning group (CCG) and national averages on these aspects of consultations with GPs and nurses. Out of 111 of the practice's patients surveyed:

- 72% of patients said the last GP they saw was good at explaining tests and treatments (CCG average 85%, national average 86%).
- 69% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 80%, national average 82%). This had improved by 1% since our previous inspection in 2015.
- 80% of patients said the last nurse they saw was good at explaining tests and treatments (CCG average 90%, national average 90%).
- 69% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 85%, national average 85%). This had improved by 2% since our previous inspection in 2015.

We raised these results with a GP partner. In line with previous results, the provider had taken no action to address or improve areas of performance that were below average. The partner told us they recognised that the practice needed to strengthen their engagement with patients and involving them in their treatment. After our inspection they told us they had begun the process of requesting training for staff from their local CCG, to improve the patient experience.

The practice provided some facilities to help involve patients in decisions about their care:

- Staff told us that translation services were not available for patients who did not speak or understand English; they informed us that they relied on patients' family members or practice staff to translate during consultations. We did not see any notices in the reception areas at the main or branch site informing patients that an interpreter service was available.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

At the last inspection on 10 February 2015, the provider demonstrated how it gave patients emotional support.

Requires improvement

Are services caring?

During this inspection, 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.

- A GP partner told us that they had worked on improving carer identification in 2015 with Bromley Carers during their previous role as the champion for carers in Kent.
- The practice's computer system alerted GPs if a patient was also a carer but the practice had identified only 13 patients as carers (0.4% of the practice list).
- There was written information in the waiting area at the main site to direct carers to the various avenues of support available to them, but this was not available at the branch site.

Staff told us that if patients had experienced bereavement, their usual GP contacted them to offer their condolences, and to offer them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At the last announced comprehensive inspection on 10 February 2015 we found that the provider demonstrated responsive care.

We found that the provider was still providing responsive care when we undertook this announced comprehensive inspection on 10 January 2017, and the provider remains rated as good for this key question.

Responding to and meeting people's needs

At the last inspection we found the practice had systems in place to ensure that the needs of patients were met.

During this inspection the practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. They had participated in a prescribing incentive scheme to reduce their prescribing of high risk or costly medicines, and broad-spectrum antibiotics.

- The practice offered a 'Commuter's Clinic' on a Monday evening at the main site from 6.30pm to 8pm, for working patients who could not attend during normal opening hours.
- Online facilities available such as appointment booking and repeat prescription ordering were available for patients.
- 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. We spoke with the manager of a local care home who told us they were very satisfied with the care provided to the home's residents by the practice's GPs.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were no baby changing facilities at the branch site. This facility was available at the main site.
- The branch site was in need of updating. The provider told us they were in the process of finalising plans to move this site to a new, more modernised location in Orpington.
- Patients were able to receive travel vaccinations available on the NHS. They directed patients to travel clinics for vaccines that were only available privately.
- The main site had wheelchair access throughout, although we observed that there was a small step at the entrance. Staff said the step had not yet adversely impacted on the ability of wheelchair users to gain access to the practice and that they would assist patients as required. There was no wheelchair access at the branch site; staff told us that if they were available they would help patients if needed.
- The practice did not offer or advertise any translation services. Staff at the main site told us that they did not offer patients an interpreter service, and that they relied on patients' family members and staff to translate during consultations. Staff spoke a variety of languages including English, Tamil, Singhalese, French and Italian. A GP partner told us that information on their website could be translated into several languages using a translation application (the accuracy of this had not been tested).
- There was no hearing loop in place at either site. Staff told us they were familiar with the few patients on their register that had hearing difficulties, and that they communicated with them in writing or by text messaging.

Access to the service

At the last inspection we found that there was good access to the service.

During this inspection the practice's main and branch sites were open from 8am to 6.30pm from Monday, Tuesday, Thursday and Friday. Both sites closed at weekends and bank holidays, and at 1pm on Wednesdays. Appointments (including extended hours) were available at the following times:

Monday: 9am-11am, 3.30pm-4.30pm (last appointment at the branch site was at 5pm), 5.30pm-8pm (late opening applied to the main site only).

Tuesday: 9am-11.30am, 3.15pm-5pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Wednesday: 9am-12pm.

Thursday: 9am-11am, 3pm-5pm.

Friday: 9am-12.30pm, 3.30pm-5pm.

Clinic times displayed at the branch site had not been updated.

The provider told us that although appointments are not available on Wednesday afternoons, the reception office remains open at the main site for patients to book appointments and drop off repeat prescription requests. A GP partner told us during the inspection that appointments could be pre-booked up to a week in advance; after the inspection they told us appointments could be booked from between two to four weeks in advance. Daily urgent appointments were available.

We spoke with eight patients; they told us that they were able to get appointments when they needed them. Results from the national GP patient survey published in July 2016 showed that patient satisfaction with how they could access care and treatment was mostly above the local clinical commissioning group (CCG) and national averages, significantly so for telephone access and making appointments. The practice was rated in line with the local CCG average and below the national average for satisfaction with opening hours. Out of 111 of the practice's patients surveyed:

- 83% of patients were satisfied with the practice's opening hours (CCG average 71%, national average 76%.
- 91% described their experience of making an appointment as good (CCG average 71%, national average 73%). This had improved by 1% since our previous inspection in 2015.
- 97% of patients said they could get through easily to the practice by phone (CCG average 70%, national average 73%). This had improved by 2% since our previous inspection in 2015.
- 93% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 74%, national average 76%).
- 61% of patients felt they did not normally have to wait too long to be seen after arriving for their appointment (CCG average 54%, national average 58%).

We raised these results with a GP partner. They told us that they attributed high levels of patient satisfaction in these areas to a strong focus on ensuring good access and continuity of care was available, previously increasing GP and nursing staffing capacity, and advising front-line staff to prioritise phone calls.

The practice had a system in place to assess whether a home visit was clinically necessary, and the urgency of the need for medical attention.

- Clinicians telephoned the patient or their carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need.
- 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

At the last inspection on 10 February 2015 we found that systems were in place to ensure patients were listened to, and complaints were managed well.

During this inspection, the practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that complaints leaflets were available at both sites to help patients understand the complaints system.

The practice had recorded two complaints they had received in the last 12 months. We reviewed these and found that they were handled in a timely manner and with transparency. Lessons were learnt 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 complaint regarding concerns about the

Good

Are services responsive to people's needs?

(for example, to feedback?)

competency of a clinician was discussed with the member of staff involved and the GP partners. The practice sent a letter of apology to the patient and implemented actions to prevent a similar incident from occurring.

Are services well-led?

Inadequate

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

Our findings

At the last announced comprehensive inspection on 10 February 2015 we found that the provider did not demonstrate well led care, as there were deficiencies in their governance processes. The provider sent us an action plan stating that they would implement the necessary improvements by December 2015.

When we undertook this announced comprehensive inspection on 10 January 2017 we found that the provider was not addressing core issues which could improve the quality and safety of the service. They had made limited improvements and the provider is now rated as inadequate for providing well led services.

Vision and strategy

At the last inspection on 10 February 2015 we found that the practice promoted and valued continuity of care. They had a vision of working with patients and staff to provide the best primary care services possible, and working within local and national guidance and regulations. The provider was not able to demonstrate any formal strategy to implement improvements to clinical performance that was below average.

During this inspection the provider described a similar vision with a slogan 'at the heart of patient-centred care' but we found that this was not reflected in all areas of the service.

- The practice had a mission statement. It was not displayed in the waiting areas at the main or branch sites but staff we spoke with knew and understood the values.
- During the provider's presentation at the beginning of our inspection they discussed a need to improve exception reporting and cervical screening, and they were in the process of finalising plans to move the branch site to a more modern and purpose-built location. However, there was no documented strategy or supporting business plans to ensure that the vision and values and any plans for improvement were implemented and regularly monitored.

Governance arrangements

At the last inspection on 10 February 2015 we found that some policies were not dated to indicate when they should be reviewed, and others had not been appropriately updated. Some staff were not aware of the provider's whistleblowing policy which contained details of organisations that no longer existed. Staff were aware of their roles and the provider had a programme of audits to monitor quality. There were gaps in training for several staff and the provider had not documented inductions for staff.

During this inspection, this GP partner told us they felt they had made improvements to the service since the previous inspection; however, we found that further improvements needed to be made across several areas of the service. The provider had not had a practice manager in place since November 2015 and a GP partner (who worked one session per week) had since undertaken overall responsibility for management and performance in the practice. The provider had an operations support manager whose role involved processing referral letters and prescription requests, managing information technology issues and appointment requests, and registering new patients. The provider told us after the inspection that the duties of the operations support manager were not exhaustive, but they did not provide us with a job description for this role.

- An understanding of the performance of the practice was not maintained in all areas by all staff members. This was in relation to the process for managing significant events and safety alerts.
- We reviewed staff files and found that there was no evidence of fire safety training or basic life support training for a non-clinical member of staff.
- The provider needed to improve documentation of various processes. For example, there were no records of an induction completed for a new nurse, fire evacuation drills conducted at the branch site, actions completed from risk assessment action plans, or actions taken in response to abnormal fridge temperature recordings at the branch site.
- There was a clear staffing structure but some staff were not aware of their roles and responsibilities in relation to chaperoning, handling clinical waste, and awareness of the location of emergency medicines.
- Practice specific policies were implemented and were available to all staff but the safeguarding policy needed to be amended to make it more practice-specific. For example it referred to a deputy safeguarding lead that staff told us was not in place, and did not include

Are services well-led?

Inadequate

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

contact details for external safeguarding leads within the borough. The provider told us, after the inspection, that they displayed posters in every room indicating details of the safeguarding lead and local details; however, they did not demonstrate that the safeguarding children policy had been updated. The policy for handling serious incidents also needed to be updated. The provider had not followed its recruitment policy in seeking background checks prior to candidates commencing work at the practice. A staff member was not aware of the practice's business continuity plan or of its use.

- There was limited evidence of the use of continuous clinical and internal audit in monitoring quality and making improvements.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effective. This was in relation to (but is not limited to) the availability of emergency medicines, conducting risk assessments for health and safety, blind cords and absent emergency medicines, ensuring that nurses had been given the proper legal authority to administer medicines, implementing a system to monitor patients taking disease-modifying antirheumatic drugs, ensuring that safety alerts were actioned, and implementing an effective system for recording and sharing significant events. Recruitment checks had not been conducted in line with the provider's policy and there was no evidence to demonstrate that this had been risk assessed. The provider was proactive at addressing some of these issues after our inspection.

Leadership and culture

At the last inspection on 10 February 2015 we found that there was no consistent structure to the meeting agendas and there was no evidence of action planning or reviews of issues previously discussed at meetings. Staff felt supported and valued by the practice's leaders.

During this inspection we found that several of the practice's processes were not being managed effectively. However, staff told us the GP partners were approachable and always took the time to listen to them.

- Staff told us there was an open culture within the practice; they said they had the opportunity to raise issues at regular team meetings and felt confident and supported in doing so.
- The provider held regular meetings which were documented, and there was a fixed meeting agenda.
- Staff said they felt respected and valued by the GP partners. All staff we spoke with said they were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The provider was aware of and had systems in place 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). The partners encouraged a culture of openness and honesty. The practice had systems in place 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.

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

At the last inspection on 10 February 2015 we found that the provider had sought feedback from patients and staff. The provider's patient survey showed that patients were satisfied with most aspects of the service and their patient participation group was active. The provider had introduced the NHS friends and family test but the results had not been collated or analysed at the time of inspection.

During this inspection the practice had sought feedback from patients, the public and staff, and engaged patients in the delivery of the service. Responses to the national GP patient survey published in July 2016 showed the practice was rated below average for aspects of care in relation to consultations with GPs and nurses. The practice was aware of this but had not implemented an effective plan of action to address this and make the necessary improvements.

- The practice had gathered feedback from patients through the patient participation group (PPG) of eight active members and through responses to their monthly NHS friends and family test. The PPG met regularly.

Are services well-led?

Inadequate

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

- The practice's patient participation group was not advertised at either site to keep patients informed but this information was available on the provider's website.
- The practice had gathered feedback from staff through informal discussions, meetings and appraisals. Staff told us they felt involved and engaged to improve how the practice was run, and that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The provider received an award from Public Health Bromley in May 2016 for achieving one of the highest Chlamydia screening rates in Bromley borough.

A GP partner was proactive at addressing issues we identified during this inspection, and they expressed a desire to make further improvements to the service. However, the provider had not addressed all of the issues that resulted in their rating of requires improvement in the two years since the last inspection in 2015.

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 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** The provider failed to enable and support all service users to make, or participate in making, decisions relating to their care or treatment to the maximum extent possible. This was in breach of regulation 9 (3) 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The provider failed to assess, mitigate and monitor risks to the health and safety of service users and others that may be at risk. • The provider failed to ensure that medical equipment and medicines were managed appropriately and safely. • The provider failed to ensure that nurses had been properly authorised to administer medicines in line with legislation. This was in breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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:

- The provider failed to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activities (including the experience of service users in receiving their services).
- The provider failed to ensure that appropriate policies were available to staff, and that policies implemented were followed.
- The provider failed to ensure that records pertaining to persons employed and the running of the service were suitably maintained.

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