Station Road Surgery

Quality Report

69 Station Road
Sidcup
DA15 7DS
Tel: 020 8308 4444
Website: www.stationroadsurgery-sidcup.nhs.uk

Date of inspection visit: 1 July 2015
Date of publication: 03/09/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection at Station Road Surgery on 1 July 2015.

We found the practice to be good for providing safe, effective, caring and services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people including those recently retired and students, people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

We found the practice to require improvement for providing well led services.

Our key findings were as follows:

- There were systems in place to ensure safe care. Policies were reviewed regularly and all staff were aware of their responsibilities in terms of the provision of care.
- The practice also had an appropriate system in place to review untoward incidents which were used to inform how services might be developed to improve patient care.
- The practice building was clean and had been redesigned to ensure that it was fit for purpose.
- Outcomes for patients at the practice were in line with or better than national averages, and a developed system of audit was in place at the practice.
- Multidisciplinary meetings were held and care was planned and shared with healthcare providers in the community.
- Patients reported that staff in the practice were caring and told us they were treated with dignity and respect.
- The practice had made efforts to ensure that care was responsive and targeted to its practice population in conjunction with the Clinical Commissioning Group (CCG).
- Information about services and how to complain was available and easy to understand. This included the practice's website which was thorough, clear and informative. Appointments could be made and prescriptions requested online.

Summary of findings

- Staff at the practice understood their roles and responsibilities and line management arrangements were clear.

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

The provider should:

- Ensure that all staff who are acting as chaperones are appropriately trained and risk assess as to whether or not clearance by the Disclosure and Barring Service (DBS) is required.
- The practice should ensure that there are appropriate means of sharing information with administrative staff.
- The practice should assure itself that all staff feel confident about raising concerns as several staff that we spoke to said that they were not. This should include formal team meetings in which administrative staff are included.

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?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise issues of concern and to report clinical incidents and near misses. Investigations into incidents were thorough and examples were provided of how services had been changed following review. Lessons were learned and communicated widely to support improvement, although for non-clinical staff this was done informally rather than by way of a formal meeting.

There was a lead GP for safeguarding, and staff at the practice understood their roles and responsibilities in this regard.

All areas of the practice were clean and there had been investment to ensure that the building was fit for purpose.

Appropriate medicines management systems were in place at the practice. Storage of medicines and vaccines was appropriate. Clinical equipment was well maintained and serviced regularly. Safety checks in the practice were noted to be undertaken, although these were not always recorded.

Staffing levels in the practice were adequate. There were thorough risk management processes in the practice and a business continuity plan was in place. The practice was well equipped to deal with emergencies on site.

However, the practice had not ensured that it had trained chaperones for their role. This was particularly relevant as some staff who acted as chaperones were neither clinically trained nor had been subject to Disclosure and Barring Service (DBS) checks. The practice had not risk assessed whether non-clinical staff required a DBS check.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

Quality and Outcomes Framework (QOF) information for the practice demonstrated good outcomes for patients and a review of patient records showed that reviews of patients were taking place at appropriate times and that patients were on correct medications. Patients' needs were assessed and care was planned and delivered in line with current legislation.

Summary of findings

The practice had developed a system audit, although it did not appear to be based on QOF findings. A number of audits had completed two cycles.

Some regular meetings took place in the practice where information was shared. At clinical meetings new guidance was discussed as were significant events and individual patient care. Representative from the practice also met regularly with other local healthcare providers and the Clinical Commissioning Group (CCG). However, non-clinical staff at the practice did not take part in regular meetings.

All staff were supported in professional development and a training matrix was kept to ensure that mandatory training was completed. The practice also demonstrated how it supported members of staff where performance improvement was required.

Are services caring?

Good

The practice is rated as good for providing caring services.

The patients and carers we spoke to said that the service being delivered was of a good quality and that they were treated with dignity and respect. They stated that they were involved in decisions that related to their care and they were treated with respect and dignity. Patients said that they were happy with the standard of service provided by the practice. This was also reported in the most recent national patient survey. The practice had a Patient Participation Group (PPG) in place.

Patient comments left by patients in the weeks before the inspection were positive, particularly relating to the friendliness of staff. This was also noted by the team during the inspection visit. Relevant information was available to patients both in the waiting area and on the website.

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

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services.

The practice had taken measures to better understand its practice population, and had taken steps to improve services, particularly in relation to improving patient access. The practice had engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to identify areas which were of specific interest to the practice population and had aimed to secure improvements to services where these were identified.

Summary of findings

The practice offered a combination of same day and pre-bookable appointments. All clinical areas of the practice were accessible to patients.

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

Are services well-led?

Requires improvement

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

The practice had a strategic vision but the vision and values for developing the practice in the future were not developed. However, staff in the practice were clear on their roles and how they contributed to the delivery of high quality care for patients at the practice.

Clinical and management leads were in place for specific areas of clinical practice, as well as for the development of policies and systems. Members of staff at the practice were all aware of who they needed to contact in specific situations. However, non-clinical staff were not involved in practice meetings. Some staff also reported that they were not confident that concerns raised would be taken seriously by managers at the practice. Line management reporting in the practice was clear and all of the records that we reviewed showed staff in the practice had already received their appraisal for last year.

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was rated as good at providing care for older people. Nine per cent of the practice population was over the age of 75 which was higher than the CCG average. The practice reported that they made full assessments for patients in this group and they were in the process of putting care plans in place.

The practice worked closely with District Nurses and palliative care providers who attended the regular clinical meetings at the practice. The senior partner in the practice also attended the regular Bexley Round Table Palliative Meetings (multidisciplinary) to improve palliative care within the practice area. The practice reported that telephone consultations were in place for patients who were not able to attend the practice. The practice also undertook a high number of home visits.

Appropriate consent arrangements were in place at the practice to ensure that families and carers could be involved in the provision of care.

People with long term conditions

Good

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

Quality Outcome Framework scores for the care of patients with long term conditions were above the local CCG average. Leads were in place for the management of long term conditions and care was split between the doctors and nurses in the practice. Where patients had multiple conditions, the practice made provision by allowing extended appointments so that all issues could be addressed in one appointment so the patient did not have to re-attend.

The practice had arranged for events to take place to educate patients about their care. An example was that in conjunction with the patient participation group (PPG) they had arranged a talk/ meeting about pulmonary disease and the value of pulmonary rehabilitation.

Nurses and GPs at the practice met regularly to discuss the management of patients with diabetes. There was information available in both the waiting room and on the practices website as to how patients with long term conditions could improve their health.

Summary of findings

Families, children and young people

Good

The practice is rated as good for providing services to families and young people.

The practice had an ante-natal clinic run by a midwife (not employed by the practice) one dayper week, and immunisations for children were available at the practice. Rates of immunisation were higher than the national average.

The practice offered contraceptive services and sexual health advice and in the last year were the highest rated practice in the Bexley for Chlamydia screening in young patients.

There was a lead GP for safeguarding at the practice (both child and adult). The safeguarding lead attended regular safeguarding lead meetings for the Bexley area. All staff in the practice were trained to a minimum of Level 1 child protection training and all clinicians had Level 3 training. Computer records were flagged if there were child protection concerns.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The practice offered appointments from 8:00am to 6:30 pm five days a week with early opening at 7:00 am once a week and late closing at 7:30pm three times per week. Appointments could be booked both on the telephone and online.

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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good at providing services for people whose circumstances might make them vulnerable.

Within the area that the practice covered there was a residential home for adults with learning disabilities. The practice recognised the importance of annual health checks for patients with learning disabilities, and they had managed to do this in over 80% of cases. In all but one of the cases where annual health checks had not been provided they had recorded that the patient had declined the offer.

The practice had a thorough set of risk assessments in place. Policies for the safeguarding of both children and vulnerable adults were in place, and members of staff were aware of the procedures

for managing any issues arising. Chaperoning services were available at the practice. However, not all staff who acted as chaperones had received the required training, and had not been cleared by the Disclosure and Barring Service (DBS).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

The practice area covered a residential home for adults with severe long term mental illness unable to live independently. The practice had regular liaison conversations with the managers of this residential home to ensure that quality care was provided to its patients.

The practice reported that they carry out annual health checks on those with significant long term mental health conditions and encourage help with smoking cessation and weight management.

The practice partners noted that the number of patients with dementia at the practice was low, and given the age demographic of the list they were actively following up patients and were looking for any warning signs during consultations. This included proactively asking patients about memory problems. Those patients who were identified as being at risk were referred onwards where required. Patients with established dementia had annual reviews which included medication reviews, blood tests, support offered for carers and safeguarding.

Summary of findings

What people who use the service say

We spoke to eight patients during our inspection and we received 18 Care Quality Commission (CQC) comment cards completed by patients who attended the practice during the two weeks prior to our inspection.

All of the patients that we spoke with said they were treated with dignity and respect by the practice staff, and that practice staff were helpful. All of the patients also commented that they felt involved in their care and that GPs and nurses were clear in their explanations. Three of the eight patients we spoke with said that making appointments at the practice could be difficult, but all of them stated that overall the practice was good.

The 18 comment cards were, in the majority of cases, very positive about the practice. Of particular note was that nine of the cards made positive comments about the helpfulness of both clinical and non-clinical staff at the practice. A total of four patients stated they were treated with dignity and respect by clinical staff. A further three comment cards stated only that the practice was good.

Five of the 18 comment cards stated appointments were sometimes difficult to access, although two of the five stated there had been recent improvement.

The practice had received 117 responses to the 2014 national GP survey (published 2015). The practice scored similar scores to or above national averages in most of the questions asked. Of particular note was that 77% of those questioned rated their overall experience at the practice at good, as compares to the clinical commissioning group (CCG) average of 78%. Feedback outside of local averages included:

- Ninety-eight per cent of patients who say the last nurse they saw or spoke to was good at treating them with care and concern, compared to a CCG average of 87%.
- Fifty-four per cent of patients who find it easy to get through to this surgery by phone, compared to CCG average of 61%.
- Forty-one per cent of patients with a preferred GP usually get to see or speak to that GP, compared to an average of 54% for the CCG area.

The practice had a patient participation group (PPG) that had been established for a number of years. Unfortunately none of the members of the PPG were available to speak to us on the day of the inspection. However, meeting minutes showed that meetings took place every two months and examples were provided of how changes had been made to the surgery following recommendations from the PPG.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all staff who are acting as chaperones are appropriately trained and risk assess as to whether or not clearance by the Disclosure and Barring Service (DBS) is required.
- The practice should ensure that there are appropriate means of sharing information with administrative staff.
- The practice should assure itself that all staff feel confident about raising concerns as several staff that we spoke to said that they were not. This should include formal team meetings in which administrative staff are included.

Station Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

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

Background to Station Road Surgery

Station Road Surgery is in Sidcup in the London Borough of Bexley in South London. The practice has four GP partners who manage the practice which is at a single site. The practice is based in a converted house, with consulting rooms based across two floors. The practice provides services to approximately 10,200 patients. The practice has a higher than average population size of patients over the age of 75, and of patients aged between 45 and 49. The practice is based in an area of low deprivation, and the life expectancy locally is the same as national averages.

The practice is a training practice and had two registrars and a foundation year two practitioner at the time of the inspection visit. As well as the GP partners, the practice employs one salaried GP. The GPs in the practice share lead responsibilities for specific areas (for example, safeguarding, and management of specific long term conditions). The practice had three practice nurses and one healthcare assistant. The practice has a practice manager, nine receptionists and a team of six secretaries and other administrative staff. A number of other health services are provided at the practice by healthcare professionals from community and hospital teams, including midwifery.

The practice is contracted for Primary Medical Services (PMS) and is registered with the Care Quality Commission (CQC) for the following regulated activities: treatment of disease, disorder or injury, maternity and midwifery services, surgical procedures, family planning and diagnostic and screening procedures at one location.

The practice provides a range of essential, enhanced and additional services including childhood vaccination and immunisation, extended hours access, Influenza and Pneumococcal Immunisations, Learning Disabilities, Minor Surgery, and Shingles Immunisation

The practice is open five days a week. Opening hours are 8:00am to 7:30pm on Mondays and Tuesdays, 7:00am to 7:30pm on Wednesday and 8:00am to 6:30pm on Thursdays and Fridays Out of hours services for the practice are provided in partnership with an external agency when the surgery is closed. The practice operates a booked appointment system.

Parking is available at the site and is shared by staff and patients.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The practice had not been inspected before.

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England to share information about the service. We carried out an announced visit on 1 July 2015. During our visit we spoke with patients and a range of staff which included GPs, practice manager, nurse, and receptionists. We looked at care records, and spoke with the management team. We spoke with eight patients who used the service, and received comment cards from a further 18 patients. We also observed how staff in the practice interacted with patients in the waiting area.

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

Good

Are services safe?

Our findings

Safe track record

The practice had good systems in place to ensure that they maintained a safe track record. The practice had an appropriate method of dealing with serious untoward events. They had followed their process for following up all of the serious untoward events in the last year, which were collated by the practice manager and discussed in clinical meetings

The practice held a range of clinical meetings with clinical staff, and also meetings that included service providers in the community. Minutes of the meetings showed that developments in practice were regularly discussed. However, there were no regular meetings involving administrative staff. Several administrative staff that we spoke with stated that they felt that this impacted on the quality of communication in the practice. The practice manager said she wanted to instigate more regular meetings with these staff.

The practice was able to demonstrate a recent example of how it had managed performance concerns with a member of staff appropriately. There were appropriate systems in place for the management of alerts in the practice involving both doctors and administrative staff. All staff we spoke with were clearly aware of their responsibilities.

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

Learning and improvement from safety incidents

Where significant events analysis had been undertaken, they were thorough and were well documented (in the case of a late cancer diagnoses all actions were clearly identifiable). We saw examples of six significant events that had occurred between 1st April 2014 and 31 March 2015. The practice apologised to patients where necessary. There had been changes to practice policies following serious events, although in several cases more could have been done to improve services in the future. An example of this was that the practice had (two years previously) had a prescription pad stolen. Although the investigation was thorough, the recommendation was a reiteration of what was current policy that pads should be kept in locked cupboards. In all of the serious events reviewed the practice had been open with patients and had shared learning with all of the practice staff. In the case of administrative staff this was completed on an ad-hoc basis as no formal meetings were scheduled.

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

Reliable safety systems and processes including safeguarding

The practice had a lead for safeguarding (the lead was the same for both children and vulnerable adults). The staff that we spoke with at the practice knew who was responsible for safeguarding and they knew the process for escalating concerns. The practice had appropriate policies in place for both adult and child safeguarding. All clinical staff in the practice had been trained in child protection to level three, with administrative staff (including those who did not routinely come into contact with patients) to level one. Contact numbers for local safeguarding teams were available for all staff. The practice had a register for vulnerable patients that was updated and reviewed regularly.

All clinical staff at the practice, including nurses, had received a Disclosure and Barring Service (DBS) check. The practice was in the process of requesting DBS for all administrative staff in the practice too. Those staff that acted as chaperones were not left alone with patients.

Clinical staff in the practice had been trained in the Mental Capacity Act (MCA) and details of this training were contained in appraisal records.

There were systems in place to ensure that the records of vulnerable children (such as those who were looked after) were flagged on the computer record. The practice also had an appropriate system for following up patients who either had a high number of attendances at Accident and Emergency or who had not attended appointments at hospital.

Medicines management

Good medicines management systems were in place at the practice. There was an appropriate cold chain process in place at the practice for the movement of vaccines. All of the medicines stored in the practice were in date and there were systems in place to ensure that they were disposed of

correctly. No controlled drugs were kept on the premises. Temperatures for the refrigerator in which the vaccines were stored were recorded. On one occasion during a stock check the temperature had been exceeded. The practice had contacted the pharmaceutical company to ensure that the vaccine was still fit for use and had acted on their recommendations. However, the practice should have contacted Public Health England in the first instance.

Anaphylaxis (emergency medicine) kits were available in rooms where vaccinations were given, and each had in date and suitable medicines in place.

Repeat prescribing processes which were appropriate and in line with guidance were in place at the practice, and GPs were aware of them. Prescription pads were kept securely in locked cupboards, all members of staff were aware where they were kept and that cupboards in which prescriptions were kept should be locked, following from an incident several years ago when a prescription pad had been stolen.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. We reviewed five clinical records of patients with long term conditions. In each of them patients had been reviewed at regular intervals. GPs detailed appropriate checks that they would take when prescribing medicines which might either have serious side effects, or might be contraindicated with other medications.

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

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. This included a situation where a doctor in training had prescribed a medicine for the treatment of psychosis for a patient with stomach pain. The two drugs were next to each other on a drop down menu on the computer screen, and the practice had changed the system so that this was no longer the case.

Cleanliness and infection control

The practice was noted to be clean throughout the premises during the inspection visit. The practice had undertaken regular audits for infection control, the most recent of which was undertaken in February 2015. Patients that we spoke with said that the practice was always clean and that they had no concerns regarding infection control. One of the nurses was lead for infection control, and the practice kept a cleaning schedule. Although the surgery had been converted from a house, the practice had invested in making the premises fit for purpose. This included the fitting of floors that curved into the wall to facilitate easier cleaning.

Staff had access to appropriate infection control equipment including gloves, hand washing gel and spill kits both in clinical and non-clinical areas of the practice.

The waiting room (including furniture), reception area and clinical rooms were all observed to be well maintained and clean. However, outside of the waiting room (which was relatively small for a practice of its size) had an overspill area into the entrance porch. There were several chairs in this area that were upholstered in cloth rather than a wipeable surface. It would be difficult to ensure that these seats were kept clean. Hand washing sinks in the practice had elbow taps. A risk assessment had been undertaken in relation to the legionella bacteria. Equipment in clinical rooms such as examination couches, scales and blood pressure monitors were also noted to be clean, and disposable rolls of paper were available to minimise the risk of cross infection.

Clinical waste disposal bins and sharps disposal systems were available in all of the consulting and treatment rooms. At the back of the practice were locked bins that were attached to the building. Clinical waste was collected by an external company and consignment notes were available to demonstrate this.

Equipment

There was appropriate equipment in place within the practice to allow for the effective delivery of clinical care. All practice equipment had been calibrated within the last 12 months, and stickers were in place to ensure that this was recorded. We were shown that equipment (such as weighing scales, spirometers and blood pressure

Good

Are services safe?

measuring devices) was last calibrated in July 2014. All electrical equipment in the practice had also been PAT tested to ensure that it was safe for use. The equipment in the practice looked to have been well maintained.

Staffing and recruitment

Appropriate staffing and recruitment processes were followed by the practice. The practice utilised a human resources (HR) consultancy service who they could contact with any queries relating to recruitment and performance management. Policies used for recruitment were based on templates but had been tailored to meet the needs of the practice.

Turnover of staff in the practice was relatively low, although a number of reception staff had retired in the last two years. All of the partners in the practice had worked there for at least ten years.

Staffing in the practice appeared appropriate given the number of patients on the list. Procedures and policies were in place to manage both planned and unexpected staff absence. The practice manager explained how she could contact other staff members to cover if the practice was busy or other members of staff were ill. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However, two staff reported that workloads could occasionally be too high.

Monitoring safety and responding to risk

A full schedule of risk assessments had not been completed in the past, but the practice manager had recently compiled a risk log which would be worked on over the coming weeks. However, there were some regular risk management checks in place which included regular checks of the building, the environment and medicines management. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Staff were aware of the policies and they had undertaken training where appropriate. The practice manager reported that all staff were aware that they should not be working in the practice alone. The practice advertised a zero tolerance policy for abuse against staff in the practice leaflet and on a notice in the reception area. However, there was no formal policy in relation to this in place in the practice.

Arrangements to deal with emergencies and major incidents

A business continuity plan was in place, which included a "buddying" arrangement with a practice about a mile away. The plan detailed how care could be delivered in the event of a range of eventualities, including the building not being fit for use. Copies were kept in the policy folder and on the shared drive at the practice, as well as at the homes of several members of staff. The practice had fire extinguishers in place throughout the practice, all of which had been serviced within the last year. The practice had undertaken a fire risk assessment, and evacuation drills were completed annually. The fire alarm was tested fortnightly and a log of the alarm tests was kept.

Appropriate systems were in place to manage on site medical emergencies. Relevant emergency equipment such as oxygen and an automated external defibrillator (which is used to re-start a patient's heart) were available in the practice, and this emergency equipment had been serviced and maintained in line with regulations. Staff in the practice had been trained in basic life support, with clinical staff being trained every 18 months and non-clinical staff every three years. However, clinical staff should be trained every 12 months.

Emergency medicines were available in secure clinical areas of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines that we checked in the practice were in date and fit for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. One of the doctors in the practice had overall responsibility for reviewing NICE guidelines and deciding which would need to be discussed at practice meetings. An example was provided of how medication changes to patients with Chronic Obstructive Pulmonary Disease (COPD) had been put in place following a discussion at this meeting.

There were leads in place for the management of long term conditions as well as other relevant areas such as safeguarding. GPs explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

The practice did not have a policy on the prescribing of antibiotics, but levels of prescribing were both discussed in meetings and audited.

Care plans were in place for some patients in the practice, however not all patients requiring a care plan had one in place which staff reported was due to the time pressures of meeting with all patients individually.

The practice had reviewed the majority of the patients on the practice with learning disabilities in the past year. They had logged where a health check had been offered but had been refused, and in only one case had the practice not received a response from the patient. A review of a random selection of patients with poor mental health showed that discharge summaries were used to inform care plans, and that missed appointments at hospitals were followed up.

The practice showed comparable outcomes for its patients with long term conditions compared to the national average. For example the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 78%, the same as the national average of 78%. The practice could also show that it was regularly monitoring diabetic patients. For example the percentage of patients with diabetes, on the register, who have a record of an albumin: creatinine ratio test in the preceding 12 months was 80% compared to a national average of 86%.

The practice also performed in line with national averages in managing patients with poor mental health. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 89% compared to 86% nationally. However, the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was only 72% as compared to 84% nationally.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. An example provided was that during audit cycles individual information was provided for each of the partners in the practice. In one case referrals for one of the partners had referred a higher than expected number of patients to secondary care. The GPs in the practice had reviewed this at the clinical meeting and taken appropriate action to ensure consistency in the future.

Audit and systems to manage and monitor care were well established in the practice. The practice provided four audits for the inspection team including those that had completed two audit cycles. The GPs in the practice told us that clinical audits were linked to safety alerts and outcomes from the Quality Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). One of the audits for Disease-modifying anti-rheumatic drugs (DMARDs) provided five options of changes that might be made to practice policies following the audit, and these options had gone to the clinical meeting at the practice for consideration. However, in other audits such as one on children who did not attend (DNA) appointments did not have clear learning points for the practice.

The practice's approach to audit was proactive; there was an audit programme and the practice did not rely on

Good

Are services effective?

(for example, treatment is effective)

untoward events to begin audit cycles. In the quality and outcomes framework score for the last year the practice scored 21 points below the highest available score for clinical outcomes, which the GPs in the practice reported as being in part due to one of the partners in the practice having left at short notice in the last year. A review of audits and patient records showed that patients with long term conditions were for the most part receiving appropriate care.

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

Effective staffing

Many of the practice staff had been at the practice for over eight years including all of the partners. A number of reception staff had retired in the past year and as such there were also a number of new staff in place at the practice. There was an employment policy in place which had been followed appropriately when appointing new staff, including checking references. All new staff at the practice were provided with an induction.

The practice had been using an e-learning system since April 2015 for all training. There was a training matrix in place at the practice to ensure that the practice manager could monitor progress of which mandatory training modules had been completed. Training in health and safety, child protection, infection control and basic life support was up to date for all staff. Staff told us they were supported in their training needs. Protected learning time was available to all staff.. One of the practice nurses confirmed she had no difficulty in arranging protected time for her professional development.

Staff in the practice had been appraised for the year 2014/5 and copies of appraisals were kept on files. Appraisals in the practice were linked to both personal development plans, and the overall development plan for the practice. GPs in the practice were either in the process of being revalidated by the General Medical Council (GMC) or they had dates agreed. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The way in which patients with long term conditions were managed showed that care was shared between the doctors and nurses in the practice. There was an appropriate skill mix in place to deliver good quality care. The regular clinical meetings at the practice allowed for individual cases to be discussed where required. Examples of this were in the minutes of the meetings.

The practice manager detailed instances where performance issues had been managed as required.

Working with colleagues and other services

The practice had a clinical meeting every other Tuesday. The practice manager stated that district nurses, members of the palliative care team and health visitors attended these meetings, which was confirmed by the minutes. This meeting ensured that patients with complex illnesses, long term conditions, or those who were vulnerable could be reviewed with healthcare professionals providing care in the community.

The practice manager reported that the practice met monthly with NHS Bexley, as well as with a group of eight practices who provided care to the local population. These meeting were designed to improve services for patients.

Notifications from the ambulance service, out of hours provider and the 111 service were received electronically and by post at the practice. An appropriate system was in place whereby the correspondence was scanned (if required) and flagged to the relevant doctor (either the named GP, or the lead for that area). More routine correspondence was shared between all of the GPs at the practice. All correspondence was managed within 24 hours of receipt.

Hospital discharge summaries were scanned onto system, or entered electronically, and passed to the GP by way of an appropriate workflow system. Changes in medications were managed by the GP with the assistance of a team of two dedicated prescribing clerks.

Appropriate systems were in place in the practice to ensure that referrals to secondary care providers and results received were managed in an efficient way. All referrals

Good

Are services effective?

(for example, treatment is effective)

were issued by a secretarial team who typed up a referral form from a template. A system was in place to ensure that this was then faxed and then acknowledgement was received. A log was kept and acknowledgements that were not received were followed up with a phone call.

Information sharing

Clinical staff at the practice met regularly, both formally and informally. However, there were no regular meetings in place at the practice for reception and administrative staff. These members of staff reported that information was shared with them by the practice manager on an "ad hoc" basis. Information was therefore not shared with the entire team, and several staff remarked that this left them feeling disassociated with the clinical staff in the practice.

Incoming results (for pathology or radiology) were downloaded to the electronic system. The practice employed several secretarial staff as well as two prescribing clerks, and robust systems were in place to ensure that all incoming and outgoing correspondence was managed appropriately. All doctors were responsible for checking their own incoming results. There was a system in place to ensure that unmatched results were shared among the doctors. Similarly there were systems in place to ensure that out of hours attendances were recorded and, where relevant, followed up.

Consent to care and treatment

All of the clinical staff that we spoke with were aware of their responsibilities in relation to consent. They also demonstrated awareness of how to assess competency in line with the Mental Capacity Act (MCA). There were also policies and protocols in place to ensure that consent was appropriately sought. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a chaperone policy in place at the practice and posters detailing the availability of chaperones were prominent in the reception area of the practice. However, some of the staff in the practice who acted as chaperones had not received the appropriate training. Non-clinical staff who acted as chaperones had also not been subject to a Disclosure and Barring Service (DBS) check.

Staff told us that consent was recorded within the patient record and if there were any issues with consent they were discussed with a carer or parent.

Health promotion and prevention

There was appropriate health promotion and prevention information available to patients at the practice. Posters and information leaflets were available in the waiting area detailing a range of health promotion interview, including services provided by the practice (such as smoking cessation clinics) and those provided in the community. There was also a wide range of health promotion information available on the practice's website.

The practice had ensured that it had offered smoking cessation to relevant patients. Although data was not available on the day of the visit, records reviewed showed that referrals had been made.

The rate of uptake for cervical smear test was 84%, which was in line with the national average of 81%. The practice also had a high uptake for influenza vaccinations. The percentage of pregnant women who had received the flu vaccination was high at 97%. The percentage of at risk groups who had received a seasonal flu vaccination was 58%, higher than the national average of 52%.

Uptake for childhood immunisations was higher than national averages for all regular vaccinations at ages 12 months, 24 months and five years. At age 24 months the uptake was 100%.

The practice had systems in place to support patients over the age of 75 who had their own named GP. GPs in the practice reported that they would proactively check health issues with older or more vulnerable patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The latest national GP survey showed that only 41% of patients were able to get an appointment with the GP that they wanted to see. This compared to a CCG average of 54% and a national average of 60%. However, 91% of patients reported that GPs gave them enough time in consultations compared to a CCG average of 83% and a national average of 87%. Ninety four per cent stated that practice nurses provided enough time compared to a CCG average of 89% and a national average of 92%. Overall 77% of patients stated that the overall experience of the practice was good. This was below the CCG average (78%) and the national average (85%).

The feedback from the eight patients that we spoke with during the inspection was positive. All noted that the practice staff treated them with dignity and respect, with several commenting specifically that staff were friendly and helpful. All but one of the 17 CQC feedback forms was positive in relation respect and dignity.

The reception area and waiting room were based in a small space, confined by the design of the building. Although the space was fairly small and reception staff were answering the telephone at the desk, we noted that conversations could not be overheard and that generally patients' confidentiality was maintained. It was also noted that reception staff treated patients politely and with respect.

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

Staff were aware of how to raise concerns about disrespectful behaviour, and zero tolerance notices were in place in both the practice leaflet and on a notice in the waiting room.

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

Care planning and involvement in decisions about care and treatment

The latest national GP survey showed that 78% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care. This compares to a CCG average of 78% and a national average of 81%. In terms of nursing staff, 95% of patients reported that nursing staff were good at explaining results and findings to them compared to a CCG average of 87% and a national average of 90%. Ninety-four per cent of patients reported that the last nurse they saw or spoke to was good at involving them in decisions about their care. This was higher than the average nationwide of 84%

Two of the responses on the CQC feedback forms specifically stated that they felt involved in decisions relating to their care, although one patient commented that doctors did not listen to what they were saying. All of the eight patients to whom we spoke said that staff involved them in their treatment.

The website contained information about how care could be accessed and how patients could communicate with the practice, including details about the practice's PPG.

Staff told us that translation services were available for patients who did not speak English as a first language, but that these were not often required. One of the practice nurses had recently begun a course in sign language to enable them to communicate better with patients.

The practice website contained a large amount of relevant information on how care could be accessed at the practice. There were also links to a wide variety of health promotion pages enabling patients to better manage their own conditions.

Patient/carer support to cope emotionally with care and treatment

The practice had a system by which all discharge letters from hospital were reviewed to see whether follow up was required, both for clinical follow up and support. The practice undertook on average six home visits per day, many of which were for patients who had recently been discharged from hospital. The practice also had a policy of ensuring that each doctor in the practice was available for four telephone consultations per day.

The practice manager stated that the practice would send a sympathy letter to patients who had suffered bereavement, and we saw evidence of these letters on patient files. She said that bereavement counselling could

Good

Are services caring?

also be offered, including specific counselling for children. There were posters in the waiting room detailing support services, and the website had a thorough list of support services including details of how they could be contacted.

We were not able to speak to any patients who were carers, and no patients that were carers commented on the CQC feedback forms.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had planned services for the needs in the local area. In particular the practice had highlighted obesity and smoking/lung cancer as high risk areas for the area, and clinics were in place to support patients in these areas. The practice had regular meetings with healthcare providers in the community to provide palliative care and for those patients with poor mental health.

The practice had arranged extended opening hours so those who were commuting could access services at more convenient hours. On Wednesday's surgeries began at 7:00am, and on Mondays, Tuesdays and Wednesdays continued until 7:30pm. Double appointments were also available for those patients who either had multiple health problems or were vulnerable. Telephone consultations (four per day for each GP) and home visits were also available.

The practice held information on patients who needed extra care and support, including those with dementia and patients who were housebound. Care plans were in place for some vulnerable patients at the practice which were formalised in one to one meetings with the patients. The practice had a thorough approach to ensuring that care plans were of benefit, and as such at the time of the inspection they had not yet been made available to all vulnerable patients.

All patients in the practice over the age of 75 were provided with a named GP. Wherever possible all care was provided through the named GP, though appropriate cover arrangements were in place.

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

The practice had a patient participation group (PPG), but no patient representative of that group was available on the day of the visit to meet with the inspection team. One of the GPs and the lead secretary at the practice were the practice representatives at the group. Minutes of meetings were provided that showed discussion about health issues relating to patients. The practice was in the process of implementing educational evenings for patients following discussion at the meetings. The first two of these were to be on pulmonary rehabilitation and dementia.

Tackling inequity and promoting equality

The practice had taken measures to ensure that they tackled inequality and promoted equality. The practice had both male and female practitioners and patients could request appointments with either if they wished to do so.

The practice used a translation service, and patients who might require this service were flagged on the patient record so the staff at the practice would know it was required. This also included a flag for patients who required a sign language translator. A hearing loop was also in place at the practice but it had not been configured for use. The practice manager said that she would attempt to resolve this.

The building in which the practice was based was a converted house, and consulting rooms were on both floors. The practice had made efforts to ensure that given the constraints of the building the practice was still accessible by all. This included providing an alternative entrance (which was clearly signposted) for wheelchair users. Patients who had limited mobility had records flagged to ensure that they were only booked to see doctors based in the ground floor of the building. One of the practice partners stated that they had made enquiries about installing a lift in the building, but this had not been possible. The patient toilets had been designed to ensure they met the needs of less mobile patients. The toilet also had appropriate baby changing facilities.

Staff told us that they did not work with any nursing homes as there were none in the area, but there were several hostels area, plus a home for patients with learning disabilities. Regular meetings were held with healthcare providers in the community to ensure those patients could access care, and records were flagged to ensure that longer appointments could be offered and yearly checks took place. Eighty four per cent of patients with learning disabilities had been reviewed and received a health check in the previous year. Of those that had not had a health check, all but one had formally declined the offer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open five days per week from 8:00am to 6:30pm. There were extended opening hours in the evening until 7:30pm on Mondays, Tuesdays and Wednesdays, and in the morning from 7:00am on Wednesdays. The practice operated a duty doctor system, although home visits and telephone consultations were shared between all of the doctors on any given day.

Practice staff reported that it was not always easy for patients to make appointments, and acknowledged that patients had fed this back to them. This was confirmed by three of the eight patients that we spoke to. They noted that it could be particularly difficult to get through to the practice on the telephone. Five of the 18 patients who completed a CQC comment card also noted problems in making an appointment, although two of the five commented that there had been an improvement recently. Appointments could be made online but the practice manager reported that the great majority of appointments were requested by telephone. The practice manager reported that most complaints related to telephone access and availability of appointments which the practice was trying to improve (by delivering a new telephone system and appointing a further GP partner).

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

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

Listening and learning from concerns and complaints

The practice had appropriate systems for learning from concerns and complaints. The practice manager was the lead for managing complaints. Information on how to make a complaint was available on a notice in the waiting room, in the practice leaflet and on the website. All staff were aware of the complaints process. There was an appropriate policy in place for the managing complaints. We were shown the yearly report on complaints for 2014/5 and a total of 12 complaints had been received. We saw a complaint made by a patient regarding difficulty in contacting the practice. This had been investigated and a new system had been put in place following the complaint. The practice had also apologised to the patient.

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

From the sample of complaints reviewed by the inspection team it appeared that they were managed appropriately and where necessary apologies were made to affected patients. The practice manager reported that they were always happy to apologise where necessary. A record of the response to the patient was also kept. Learning from events was shared with clinical staff at meetings. However, learning was shared on an informal basis with non-clinical staff as regular meetings were not in place.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a statement of purpose in place, of which staff in the practice were aware. However, there did not appear to be a clear long term vision or strategy within the practice. In part this was explained by the partners who said that because a previous practice partner had recently left the practice they were primarily focussed on replacing the partner before delivering a strategy for the future of the practice. Although there was not a clear vision for the practice, staff understood that the primary goal for the practice was the delivery of good clinical care.

Governance arrangements

Appropriate governance arrangements were in place at the practice. Meeting minutes showed that issues requiring development were discussed in a formative way. A range of policies and procedures were in place at the practice which governed how clinical and other issues should be managed. The policies in place in the practice had been discussed and reviewed as appropriate. This included registration with the Information Commissioner's Office, and Employers Liability Insurance was in place.

The leadership structure of the practice was clear and there were named staff in lead roles, for example one of the GP partners was the lead for safeguarding. We spoke with eight members of staff and they were aware of their roles and responsibilities. They told us that information was fairly well shared in the practice, but they felt that both clinical and non-clinical staff in the practice would benefit from a more formalised system of team meetings. Some meetings were held at the practice including fortnightly clinical meetings, but there were no formal meetings for administrative and reception staff. As such, there was only a limited record of how information had been shared with staff.

The practice had completed a number of relevant audits, including two that were observed to have completed two full audit cycles. However, it was not clear how the choice of audits had been made, and it was not linked directly to the practice's performance in the Quality and Outcomes Framework (QOF)

Leadership, openness and transparency

There were clear line management arrangements in place at the practice, and these were defined in job descriptions. There were leads in place for a number of areas of responsibility including for the management of long term conditions and safeguarding. Staff we spoke with were aware of who respective leads were and they knew when, and to whom to report issues of concern.

Administrative and reception staff reported that they were aware of their responsibilities, and they knew where any issues of concern could be raised. However, they did not feel that communication in the practice was always effective. This was most noticeably the case in that there were no regular meetings involving these staff, but they also reported that communication between clinicians was not as good as it should be.

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

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

The practice demonstrated that it acted on patient feedback. The patient participation group (PPG) at the practice was longstanding, and the minutes of the meetings showed close working relationships. The practice manager stated that disabled access was better signposted following feedback from the group, and they were now planning to make the front of the building wheelchair accessible. The practice was also in the middle of undertaking a "friends and family" test at the time of the inspection. (This involves asking patients whether or not they would recommend the service to friends and family.)

The practice also sought feedback from staff. Members of staff said they knew who to approach if they wished to raise an issue, and that the practice manager told us the practice management took comments from staff seriously. She said that staffing had been increased following staff feedback. However, three of the staff that we spoke to said they were not assured that their view would be taken seriously.

An appropriate whistleblowing policy was in place at the practice.

Management lead through learning and improvement

Are services well-led?

Requires improvement

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

Systems were in place at the practice to ensure that it learned from significant events and feedback to improve the service being provided for patients. Significant events were individually reviewed and action points put in place to prevent reoccurrence. When discussing significant events during the inspection, practice staff were candid and open. It was clear that adverse events were used as a mechanism for positive change.

Members of staff were supported in their professional development, and one member of staff noted that she had been provided protected time for this. A learning matrix allowed the practice manager to monitor how practice staff were performing in achieving their mandatory training. Staff said that information was shared with them, but administrative staff in particular noted that without regular meetings they were not included in developing the service in the future.

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