Care Quality Commission

The Whitehouse Surgery

Quality Report

123 Towncourt Lane
Petts Wood
Orpington
Kent BR5 1EL
Tel: 01689 821551
Website: http://www.whitehousesurgeryorpington.co.uk/

Date of inspection visit: 13 February 2015
Date of publication: 18/06/2015

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The White House Surgery on 13 February 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, responsive and well-led services. It also required improvement for providing services to people whose circumstances may make them vulnerable, and working age people (including those recently retired and students). It was good for providing a caring and effective service. We also found it was good for providing services to older people, people with long-term conditions, families, children and young people, and people experiencing poor mental health (including people with dementia),.

Our key findings across all the areas we inspected were as follows:

- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Urgent appointments were usually available on the day they were requested.

The areas where the provider must make improvements are:

- Ensure complaints and incidents are consistently recorded, monitored and addressed so that improvements are made to the service provided. Any improvement strategies must be shared and understood by all members of staff.

In addition the provider should:

Summary of findings

- Ensure that all staff who act as chaperones have been trained to do so and have undergone a risk assessment to determine the need for a Disclosure and Barring Service (DBS) check.
- Review the protocols for repeat prescribing to ensure that non-clinical staff cannot override automated systems without prior approval from a GP.
- Carry out an annual infection control audit to identify and address any risks to patient safety.
- Improve the support of newly recruited staff, including locum staff, through the use of up-to-date induction processes and formal supervision arrangements.
- Develop a co-ordinated approach to monitoring flu vaccine uptake to identify strategies for improving performance.
- Improve the availability of appointments outside of normal working hours.
- Improve communication between staff and patients about development plans for the practice.

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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong there was not always a co-ordinated response which involved both clinical and non-clinical staff review. Some complaints, which constituted 'no harm' incidents, had not been escalated appropriately for clinical review.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, an annual infection control audit had not been carried out and the protocols for repeat prescribing did not have adequate clinical oversight.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Data showed patient outcomes were generally good for the locality and some audits were being used to improve patient outcomes. Staff worked with multidisciplinary teams.

The practice had implemented some effective health promotion and preventative care, but was not performing consistently well. For example uptake of general health checks was low and the practice did not have a co-ordinated approach to monitoring their performance in relation to flu vaccine targets.

Are services caring?

Good

The practice is rated as good for providing caring services. Survey data generally showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect.

Summary of findings

Are services responsive to people's needs?

Requires improvement 

The practice is rated as requires improvement for providing responsive services. Feedback from patients reported that access to a named GP and continuity of care was good and urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs.

Patients could get information about how to complain in a format they could understand. However, not all of the written complaints were consistently recorded, investigated or monitored by clinicians. Verbal complaints were not consistently recorded or monitored for recurring themes.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. It had a vision and a strategy and staff were aware of this and their responsibilities in relation to it. There was a leadership structure and most staff felt well-supported by management. The practice proactively sought feedback from patients although it did not have a patient participation group (PPG).

There were some human resource issues related to the use of locum staff which could be improved. Locum staff either had not received a formal induction, or needed to rely on out-of-date information in induction packs.

The leadership of the practice had not communicated consistently the future plans for the practice with staff and patients. One of the GP partners was in the process of retiring, but agreed plans had not been shared with staff or patients. The other GP partner and practice manager provided contradictory information on the timescale for this retirement compared to the retiring GP partner, indicating some confusion as to the succession plan.

Summary of findings

The six population groups and what we found

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

Older people
The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There were systems in place to follow up patients who had attended accident and emergency (A&E) and this had led to more appropriate onward referrals for older people to services such as occupational therapy, and falls or memory clinics.

Good

People with long term conditions
The practice is rated as requires improvement for the care of people with long-term conditions. Patients who were at risk and who might need urgent care were prioritised for appointments. Longer appointments and home visits were available when needed. All these patients had a named GP and were recalled for appropriate health checks and reviews of medicines.

Good

Families, children and young people
The practice is rated as good for the care of families, children and young people. Staff had all completed training in child protection. The contact details of the local area's child protection services were accessible to staff in the reception area. Immunisation rates were relatively high for all standard childhood immunisations compared to rates in the overall local area. Patients told us that children were seen promptly and staff told us they gave children access to priority appointments with the GP or nurse. There was a community midwife who held regular clinics at the practice. The midwife told us she was satisfied with the arrangements for joint working with the GPs at the practice.

Reception staff knew that young people could book their own appointments. Clinical staff understood their responsibility to check that young people had the maturity to make their own treatment decisions.

Good

Working age people (including those recently retired and students)
The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The age profile of patients at the practice is mainly those of working age, but the services available did not fully reflect the needs of this group. Patients could book appointments and repeat prescriptions online, but the practice did not offer any extended opening hours to enable patients to attend the practice either before or after their normal working hours.

Requires improvement

Summary of findings

Health promotion advice and general health checks for people over the age of 40 years were offered, but the uptake of this service was low. This suggested the practice did not support people of working age, or those recently retired, to implement preventative health measures or effectively identify pre-cursors of potential illnesses.

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. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. The practice had made appropriate changes to the layout of the premises to enable people with physical disabilities to access the services.

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.

However, not all staff engaged in chaperoning activities had had background checks with the Disclosure and Barring Service (DBS) and no risk assessment had been carried out to determine if these were required. Not all staff had received formal training around chaperoning duties.

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). One of the GP partners was the designated lead responsible for reviewing patients' mental health. The practice had carried out some work to assess and improve its identification of people with dementia. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

We spoke with eight people during our inspection. Another eight people completed comment cards. The majority of the feedback from patients was positive about the care they received from both clinical and administrative staff.

Most people told us they found it easy to make appointments. Appointments could be made in advance or, for more urgent matters, people could be seen on the day they rang the surgery. People with families registered at the practice told us they knew appointments for children could be prioritised so that they could see their GP when they needed to.

Patients told us they generally understood the explanations given by clinical staff. They were provided with good information about their diagnosis and treatment options. People felt well supported and cared for by the clinical staff. Their privacy and confidentiality was respected.

Patients thought there were good systems in place for obtaining repeat prescriptions and for obtaining referrals to other services in a timely manner. Patients who needed regular check-ups told us the administrative staff contacted them to make an appointment at the right time.

Areas for improvement

Action the service MUST take to improve

- Ensure non-verbal and verbal complaints are consistently recorded and monitored to identify any recurring themes as well those complaints which may require escalating as serious adverse events.

Action the service SHOULD take to improve

- Carry out an annual infection control audit to identify and address any risks to patient safety.
- Review the protocols for repeat prescribing to ensure that non-clinical staff cannot override automated systems without prior approval from a GP.
- Carry out a risk assessment for all members of staff who may be called upon to act as chaperones to determine if they require a Disclosure and Barring Service (DBS) check.
- Provide training in chaperoning duties for staff who act in this capacity.
- Develop and communicate a clear succession plan to staff and patients in anticipation of the retirement of one of the GP partners.
- Review staff induction processes and packs to ensure these are current and up to date. This includes induction processes for locum staff.
- Work towards improving access to appointments for the working age population including the possibility of offering extended opening hours.
- Develop a co-ordinated approach to monitoring performance in relation to flu vaccine uptake to identify areas where improvements could be made.

Care Quality Commission

The Whitehouse Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our team was led by a CQC Lead Inspector. The team also included a second CQC inspector, and a GP Specialist Advisor who was granted the same authority to enter the practice premises as the CQC inspectors.

Background to The Whitehouse Surgery

The Whitehouse Surgery is located in Orpington, Kent. The practice serves approximately 3,400 people living in the local area. The practice operates from a single site. It is situated in a residential, two-storey building which has been converted for use as a primary care surgery.

There are two GP partners working at the practice; one is male and one is female. There is a locum practice nurse and a health care assistant. The practice also hosts sessions for a visiting community midwife and offers a diabetes clinic. The practice is a registered teaching practice with a local NHS foundation trust and provides some training opportunities to medical students.

The practice offers appointments on the same day and takes bookings up to six weeks in advance. They also offer telephone consultations and home visits for patients who are not able to visit the surgery. Patients can access the appointments system on the phone and through the practice website. Patients can sign up to a telephone text reminder service to prompt them to attend the surgery at the right time.

People who need higher levels of support from their GP, for example, because they are living with a long-term health condition, are flagged on the computer appointments system so that receptionists can ensure they are given priority access to the GP. Longer appointments are available with the practice nurse for people who need them.

The White House Surgery is open on weekdays from 8.30am to 6.50pm, except on Wednesdays when it is open from 8.30am to 12.50pm. There is a GP available 'on call' on Wednesday afternoons. Patients can ring to speak to a GP who will provide them with advice or arrange a home visit, as necessary. The practice does not offer out-of-hours services and patients are directed to the nearest Urgent Care Centre. There are arrangements with other local practices for patients from the White House Surgery to access minor surgery treatments.

The White House Surgery is contracted by NHS England to provide General Medical Services (GMS). The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, contraception services and minor surgery.

The practice is registered with the Care Quality Commission to carry out the following regulated activities: maternity and midwifery services; diagnostic and screening procedures; treatment of disease, disorder or injury; family planning; and surgical procedures.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of

Detailed findings

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.

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 that we hold about the practice. We carried out an announced visit on 13 February 2015. During our visit we spoke with a range of staff. We spoke with two GPs, the locum practice nurse, a health care assistant, a community midwife, a practice manager, three reception staff and a secretary. We spoke with eight patients who used the service and reviewed eight comment cards where patients shared their views about the service. We observed patient and staff interactions in the waiting area. We conducted a tour of the surgery and looked at the storage of medicines and equipment. We reviewed relevant documents produced by the practice which related to patient safety and quality monitoring.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety. The practice manager told us of the arrangements they had for receiving and sharing safety alerts from other organisations such as the Medicines and Healthcare Products Regulatory Authority (MHRA) and NHS England. The practice had a significant event policy and a toolkit to report the incidents. The practice manager showed us the processes around reporting and discussions of incidents.

Significant events were reviewed regularly; we saw that two had been reported in the past 12 months. Staff we spoke with were aware of the need to identify concerns and issues and how to report them. The provider had policies and procedures in place for safeguarding, infection control, and health and safety.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring incidents and significant events. There was evidence of learning and actions taken to prevent similar incidents happening repeatedly. For example, the practice identified a case where a positive test, which was potentially indicative of cancer, had not been acted on appropriately by a referral consultant. The practice manager showed us evidence that this event had been raised and discussed with clinical staff. Action plans were implemented to ensure the risk of this happening again was reduced. The practice identified a missed communication and delays in the referral process, which delayed treatment to the patient. The practice referred the patient again and ensured that the patient received the correct investigations, treatment and further appointments. The practice introduced a system of checking discharge summaries and referrals to ensure they were received, read and acted on. Patients with possible cancer were now followed up and their progress checked regularly. If nothing had been heard from a hospital within a reasonable time frame they would be contacted and reports chased.

The staff we spoke with were aware of significant event reporting protocols and knew how to escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice. However, we found two incidents which related to verbal and written complaints which should have been investigated as incidents or significant events. The first related to someone being given a prescription that was meant to have been issued to someone else. The second related to reception staff making an inappropriate referral to the '111' service. In both of these cases no harm occurred to the patients This showed that, although staff knew the reporting protocols, they did not always follow the correct procedures or identify concerns as they arose.

These two incidents were investigated as complaints and some improvements were implemented. However, in one case the practice could not show that a discussion had taken place with clinical staff about the action plans that were being put in place. Therefore it was possible that not all of the appropriate clinical implications of the complaint had been identified and acted upon to keep people safe.

Reliable safety systems and processes including safeguarding

The practice had policies in place related to the safeguarding of vulnerable adults and child protection. The practice also had a whistle blowing policy which was available to all staff. Staff understood and were aware of the policy. One of the GP partners was the designated lead for safeguarding. Staff we spoke with were aware of their duty to report any potential abuse or neglect issues.

Clinical and administrative staff had all completed vulnerable adult safeguarding training. GPs had also completed Level three child protection training. The locum nurse had been trained to Level two and reception staff had completed Level one child protection training. Clinical staff were required to have a criminal records check with the Disclosure and Barring Service (DBS). The contact details of the local area's child protection and adults safeguarding departments were accessible to staff in the reception area if they needed to contact someone to share their concerns about children or adults at risk.

The practice had an up-to-date chaperone policy. This provided patients with information about the role of a chaperone and clinical staff were aware of their role and responsibilities. Clinical staff who were responsible for chaperoning duties were suitably checked with the DBS.

Requires improvement

Are services safe?

However the practice reception staff were also occasionally providing this service at the request of GP's, but they had not been subject to a DBS check or been trained in chaperoning duties.

Medicines management

The practice had procedures in place to support the safe management of medicines. Medicines and vaccines were safely stored, suitably recorded and disposed of in accordance with recommended guidelines. We checked the emergency medicines kit and found that all medicines were in date. The vaccines were stored in suitable fridges and the practice maintained a log of temperature checks on the fridges. Records showed all recorded temperatures were within the correct range and all vaccines were within their expiry date. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably. No controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were kept on site.

GPs followed national guidelines and accepted protocols for repeat prescribing. Prescription documentation was used in a safe and secure manner, with prescription pads being secured safely when not required. All prescriptions were reviewed and signed by GPs. Medication reviews were undertaken regularly and GPs ensured appropriate checks had been made before prescribing medicines.

There was a protocol for repeat prescribing, which was in line with national guidance. Reception staff who were responsible for issuing repeat prescriptions showed us that their computer system alerted them to the need for a prescription review by the GP. The system also alerted them to any potential overuse of medicines. There had been some issues with the repeat prescribing protocol which had been discussed at a staff meeting. We noted the GP partners did not agree on the level of clinical monitoring that was required for this system to be effective. Currently reception staff could override the computer system without the need for alerting the GP if they had manually checked the need for a repeat prescription.

Cleanliness and infection control

Systems were in place to reduce the risk and spread of infection. There was a designated infection prevention and control lead for the practice, who was the practice nurse. The practice nurse was in the process of completing distance learning for infection control policies and procedures. Staff had received training in infection prevention and control and were aware of infection control guidelines. Staff told us they had access to appropriate Personal Protective Equipment (PPE), such as gloves, aprons and spills packs.

There was a cleaning schedule in place to ensure each area was cleaned on a regular basis. The practice manager checked the work of the cleaning staff by reviewing the completion of the schedules against standards of cleanliness seen in each area. Wastes, including sharps, were disposed of appropriately. Hand washing sinks, hand cleaning gel and paper towels were available in the consultation rooms, treatment rooms and toilets. The equipment we saw, such as blood pressure monitors, examination couches and weighing scales were clean. Clinical waste was collected by an external company and consignment notes were available to demonstrate this. Water testing to check for legionella was completed regularly and was also subject to annual testing, the last test having been completed in June 2014. However, no infection control audit had been carried out within the past year to determine if these protocols had been effective.

Equipment

There were appropriate arrangements in place to ensure equipment was properly maintained. These included annual checks of equipment such as portable appliance testing (PAT) and calibrations, where applicable. These tests had last been completed in July 2014.

Staffing and recruitment

A staff recruitment policy was available and the practice was aware of the various requirements including obtaining proof of identity, proof of address, references and completing health checks before employing staff. We looked at a sample of clinical and non-clinical staff files and found evidence that checks had been undertaken as part of the recruitment process.

Clinical staff had all had a Disclosure and Barring Service check (DBS). However, non-clinical staff had not had a DBS check. There was no formal risk assessment to determine whether or not non-clinical staff would need to have such a check. We found that non-clinical staff were occasionally acting as chaperones during clinical consultations. Therefore non-clinical staff may also have needed this check.

Requires improvement

Are services safe?

All staff files reviewed contained a contract of employment. Rotas showed safe staffing levels were maintained and procedures were in place to manage planned and unexpected absences.

Monitoring safety and responding to risk

The practice manager explained the systems that were in place to ensure the safety and welfare of staff and the people using the service. Risk assessments of the premises including the potential for trips and falls, Control of Substances Hazardous to Health (COSHH), security, and fire had been undertaken.

The reception area could only be accessed via a security-locked door to ensure security of staff and prevent inappropriate access to computers or patient documents. Patient documents stored behind the reception desk did not have names visible to the public in order to maintain patient confidentiality. However, patients could potentially access the reception area as they moved between the consulting rooms and the waiting area. Practice staff told us they did not allow patients to come into the reception area and the reception desk was not left without a member of staff in attendance. However, we also observed that an individual's notes had been left in an unattended and unlocked consulting room. Therefore there was some small risk that people's individual notes could have been accessed inappropriately. We discussed this with the practice manager who assured us they would actively seek to minimise these risks further.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to deal with on-site medical emergencies. All staff received training in basic life support. Emergency medicines and equipment such as an Automated External Defibrillator (AED), oxygen, masks, nebulisers and pulse oximeter were available and these were checked regularly. However, emergency equipment was stored in two separate locations. Staff knew how to use the AED and equipment at the practice and where it was situated.

The practice manager told us that fire alarm and panic alarms within the practice were tested on a weekly basis within the practice. Fire risk assessments were completed annually. We were able to see that this was last completed in August 2014.

A business continuity plan was available and the practice manager told us of the contingency steps they could undertake in the event of any disruption to the business model, the premises' computer system, and telephone lines. Staff had access to panic alarms which were available to all staff and within all consultation rooms. These were checked weekly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with National Institute for Health and Care Excellence (NICE) guidelines. There were regular clinical meetings, and separate administrative staff meetings. The practice manager attended both meetings to ensure relevant information was shared. However, the minutes from these meetings suggested that new guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners were not regularly discussed.

The practice had care plans which were developed jointly by clinical and administrative staff. High risk patients such as those with long-term conditions were identified and flagged on the practice appointments system so that they could receive fast track care when they needed it. We reviewed some care plans and found they were well developed and had appropriate alerts in place.

The practice offered a specialist diabetes clinic, but did not offer any other specialists clinics. We discussed this with the GP partners who told us they had tried to implement other clinics, such as for those with chronic obstructive pulmonary disease (COPD), but they had found these were unsuccessful due to the small numbers of patients requiring these services. Therefore people with these types of conditions were seen during normal surgery hours.

The patients and families we spoke with who needed regular reviews, because of their long-term conditions or other physical or learning disabilities, told us they were regularly called for a health check. The GPs attended meetings with the local palliative care team to co-ordinate care for people nearing the end of their lives.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Administrative staff were trained to follow up referrals. The GPs used national standards for referral. For example, urgent cancer referrals for people who needed to be seen within two weeks were followed up by staff to check they had actually been seen and any follow up actions had been implemented by the practice. Overall we found the practice had a robust system for referring patients to secondary care and reliable systems for checking that referrals had been made and completed.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had some data which referred to clinical audits. They showed us information relating to clinical audits for diabetes, dementia care and atrial fibrillation patients. The practice had identified some learning points from each audit. The practice could show a continuous cycle of audit for dementia care and one of the GP partners discussed the completion of a second audit for atrial fibrillation with us, although the results had yet to be formally analysed or written up.

The initial audit for dementia care had been carried out in October 2014 because the practice had noted that the number of patients on the dementia care register was lower than the number expected for the practice population. The practice had sought to improve identification and recording of patients diagnosed with dementia through the use of efficient computer coding and implementation of a Dementia Screening Tool. The audit was repeated in January 2015 and found that although some new cases had been identified, the numbers of patients diagnosed with dementia remained low compared to the expected number in the population.

There had been no audit of either medicines management or infection control within the past year. The GP partners and practice manager told us this would usually have been carried out by the practice nurse. However, as this post had been vacant, and was currently filled by a locum nurse, no such auditing had taken place.

The practice did review their performance in relation to their quality and outcomes framework (QOF) submission. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing

Good

Are services effective?

(for example, treatment is effective)

some of the most common long-term conditions and for the implementation of preventative measures. QOF data was regularly discussed at monthly team meetings and plans were implemented to improve outcomes.

The data from the practice's QOF submission showed they performed well against national-level performance data. For example, 100% of patients with atrial fibrillation, measured within the last 12 months, were currently treated with anti-coagulation drug therapy or an anti-platelet therapy which reflected well against the national average of 98%. This practice was not an outlier for any QOF (or other national) clinical targets.

The performance of staff was checked during regular peer review meetings between GPs. GPs had also attended revalidation and appraisal meetings. The locum nurse who had been working at the practice for the past five months told us she had good access to the GPs to discuss any clinical issues. However, no formal notes from either the peer review or supervisory meetings between the GPs and the nurse were kept in order to record any on-going issues or areas identified for improvement.

The practice manager or one of the GP partners attended local CCG and practice cluster meetings. Any changes in service or new services were discussed and shared at the staff meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff.

There was one practice nurse post which had been filled by a locum nurse for the past five months. A new practice nurse was in the process of being recruited. The locum nurse told us they had not had any formal induction when they started working at the practice. We also noted that, although there was an induction pack for locum GPs, this had not been updated for some time and was no longer fit for purpose. The pack contained information about services that were no longer available, had not been updated to reflect new services that were offered, and contained out-of-date telephone numbers.

All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

All staff undertook annual appraisals and we reviewed some of the records kept in relation to these. We found there was no systematic mechanism to identify learning needs. However, staff told us, and the records demonstrated, that staff had completed relevant training courses. There was a training schedule which set out which members of staff were due to renew or start different courses. For example, all staff had completed safeguarding training and were due to complete a course in basic life support skills later in the year. The practice was registered as a training practice and medical students were provided with support from one of the GP partners.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. For example, the practice manager showed us how they received and dealt with summaries from out-of-hours GP services and 111 services. The GP partners had established time frames within which to review the information received to ensure that any issues were identified and followed up.

The practice manager also showed us data from a recent pilot project which the practice had engaged in with the local hospital accident and emergency (A&E) department. The hospital shared data on which patients from the practice had visited A&E. The practice manager reviewed each case to determine whether care could have been provided by the surgery. The practice manager indicated this had led to changes in care. For example, some patients had been referred for extra support to an occupational therapist, physiotherapist or falls clinic.

The practice held multidisciplinary meetings at least every three months to discuss the needs of complex patients including those with long-term conditions. The GP partners, nurse and practice manager attended these meetings. However, we noted that the health care assistant was not included in these discussions. The community midwife told us she had good access to the GP partners to discuss any cases where she had concerns.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to communicate efficiently with other providers. For example, the practice manager received all data via email from the out-of-hours providers. The practice used the Choose and Book system for referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient records to coordinate, document and manage patients' care. Staff were trained to use the system and paper communications, such as those from the hospital which could be scanned and saved onto the system for future reference.

Consent to care and treatment

Staff had received some training in relation to the Mental Capacity Act 2005. We asked clinical and administrative staff about their understanding of the implications of the Act, as well as their legal responsibilities to children and young people as set out in the Children Acts 1989 and 2004. Staff were able to demonstrate knowledge and understanding of the Acts and provide examples of when they had used this training to ensure the care and welfare of vulnerable patients and children. Administrative staff knew how to escalate any concerns they may have to appropriately-trained clinical staff within the practice. The practice had drawn up a policy for working with people under the age of 18 years. Reception and administrative staff knew that young people could book their own appointments. 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).

The practice was a GP undergraduate teaching practice, taking medical students throughout their time at a local NHS Foundation Trust. Patients would be given the option to have their appointment with a student present, but only with agreement from the patient, who had the right to decline. Information telling patients about this service were displayed within the waiting area, on the practice website and in a practice information leaflet given to newly registered patients.

Health promotion and prevention

The practice offered a 'new patient check' with the practice nurse to all patients registering at the practice. This was used to identify any health concerns which were then followed up by the GPs. The practice had systems in place to monitor patients who needed additional support. For example, they kept a register of patients with a learning disability and invited them to receive an annual health check. We spoke with one family about the service offered by the practice for people with learning or physical disabilities. They told us they were well supported by the practice and their family member who had some learning and physical disabilities regularly attended for appointments and reviews.

We noted the service was promoting the use of chlamydia screening and packs were available in the waiting area for people who wanted to take a test. The practice performance regarding cervical smear uptake was good with 80% of eligible women having completed the test. This is comparable to the national average of 82%. A full range of immunisations for children, travel vaccines and flu vaccines were offered, in line with current guidance. QOF data indicated high levels of uptake of children's immunisations. The practice either met or exceeded the national average for uptake of all children's immunisations.

The data we reviewed indicated that the practice had not had high levels of uptake of the flu vaccine. 64% of people in the clinical risk groups who are encouraged to receive this vaccination had taken up the offer. This is somewhat below the national average of 73% and below the national target set of 75%, although the practice's uptake remains within what is considered an acceptable range. We asked the practice to provide information on flu vaccine targets or uptake to see what actions they had taken to monitor this activity. We found that the practice did not have a co-ordinated approach to monitoring flu uptake as neither the practice manager or nurse were aware of how the practice was performing in relation to flu targets.

The practice offered NHS Health Checks to patients aged 40 to 75 years. However, the practice had low uptake of this check. Only 73 (8%) out of 934 eligible patients had a completed Health Check at the practice. The practice manager and GP indicated that the current lack of a full-time nurse may have impacted on these aspects of service delivery and that improvements could be made next year following the recruitment of a new nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comments cards to tell us what they thought about the practice. We received eight completed cards. The majority were positive about the practice and its staff. We also spoke with eight patients during our inspection; they were also mostly positive about the service experienced. Patients said reception staff were helpful, the clinical staff were caring and they were treated with dignity and respect. Only two comments were negative and these related to access to appointments.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (July 2014). 79% of respondents with a preferred GP usually got to see or speak to that GP. This was well above the overall response in the local area (59%) and demonstrated that patients had good choice about who they saw when they went to the surgery. However, there were areas where the service could improve. For example, only 70% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, which, although high, was considerably lower than the local average of 82%.

We observed reception staff spoke to people respectfully. Patients could request to speak to staff in a side room if they wanted more privacy. Staff had been given written guidance on how to approach sensitive issues in the reception area. There was a sign in the reception area reminding staff to be careful as regards discussing patient issues in case they were overheard. The computers containing patient records were kept well away from any area where members of the public might be able to see them. Staff had received training in relation to information governance including good practice as regards data protection and confidentiality. The patients we spoke with told us they felt their privacy was well protected and they were not concerned about their conversations being overheard.

Patients who had concerns about investigations being carried out by a GP of a different gender to themselves could request to see a particular GP. Clinical staff could also act as chaperones by being present alongside the GP during any consultations.

We observed treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. There were also curtained areas in the treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the patients responded positively to questions about involvement in treatment and planning, but there was room for some improvement. For example, 68% of patients at the practice reported that the last GP they saw or spoke to was good at involving them in decisions about their care, which was somewhat lower than the national-level results (75%). The practice manager told us this was an area they thought they could improve. The issue had been discussed with the clinical staff to encourage them to explain fully to patients what treatment they were proposing and any tests that were required so that the patients could become better involved in the decision-making process. GPs had also discussed the using an electronic medical information system computer library for accessing a wider range of patient information leaflets. The patients we spoke with told us they generally understood the explanations given by clinical staff, but that there was some variation depending on which person they saw.

Overall the patients we spoke with, and the comments cards we received, commented positively on the level of support and involvement they had experienced from all members of staff at the surgery.

Staff told us that translation services were available for patients who did not have English as a first language. The practice manager and reception staff knew which patients might require this service and how to organise a translator in advance of any appointment.

Patient/carer support to cope emotionally with care and treatment

The waiting room contained a variety of leaflets and a TV screen display which told patients how to access support groups and other relevant organisations. The practice had access to a named counsellor and this service was advertised on their website. The patients we spoke with who saw the GP regularly, because of either a long-term condition or disability issue, told us the practice

Good

Are services caring?

pro-actively called them to attend for check-ups. They felt well cared for and supported by the practice. The practice also had a register of people with learning disabilities to ensure they were called for a yearly check.

Patients nearing the end of their life were referred to the local palliative care team for treatment and support. The GPs attended meetings with the palliative care team to co-ordinate care for people nearing the end of their lives.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We explored how the practice received feedback from patients. The practice did not have a Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have an interest in the services provided. However, the practice had recently implemented the 'Friends and Family Test'. This is a short survey which all GP practices are asked to use in order to collect patient feedback. Patients at The White House Surgery were able to complete this test online or on paper forms in the reception area. The practice had received five completed tests within the past month, of which four were entirely positive. The practice manager was aware of the concerns raised by one patient and was considering how the practice could respond.

The practice manager had also analysed results from the National Patient Survey and developed an action plan to address areas where the practice had performed less well. For example, the practice manager had tried to address shortfalls in patient satisfaction as regards the booking of appointments by promoting the use of the online booking system through advertising in the waiting area. There was also a longer-term commitment to offering extended hours, including early and late appointments. This would be implemented following the successful recruitment of another salaried GP.

The practice was comparatively small in size and therefore staff could demonstrate that they knew their patients well. For example, reception staff knew which patients had special access requirements. The patients we spoke with commented that the practice environment was friendly and supportive, and that clinical and administrative staff were helpful.

The practice offered some specialist clinics, including a diabetes clinic. There was also a community midwife who held regular sessions at the practice. The GPs told us that attempts to offer a wider range of specialist clinics had been unsuccessful due to the small numbers of patients requiring these services.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The building had been assessed for its adherence to the recommendations set out in the Disability and Discrimination Act (1995). The practice had implemented some changes to ensure that the building had good access for people with disabilities. For example, there was an access ramp, a disabled toilet, and entrance bell at wheelchair height. Consulting rooms were all on the ground floor. We spoke with one family who needed wheelchair access. They told us the corridors were relatively narrow between the reception area and the consulting rooms. However, reception staff knew the patients well and helped them to access the building via the ramp at the rear entrance.

There was a hearing loop in the reception area and in one of the consulting rooms. Reception staff could also tell us who might need to use these facilities and were also aware of the number of patients registered with the practice who were visually impaired. Families with children in buggies or prams were welcomed in the reception area. This area also contained a child-friendly space with some toys and books to engage children while they were waiting.

The majority of the practice population were English speaking, but the practice also had access to telephone translation services for those who needed it. One of the reception staff told us they had basic sign language skills. They could also organise a skilled signer to be present during a consultation if a patient requested this service.

The practice promoted a policy of providing access to all, including providing appointments to people who needed to see a GP quickly, but who were not officially registered at the surgery. For example, the practice manager described systems for visiting patients to enable them to be seen at short notice or on the same day, as necessary.

Access to the service

The practice was open on weekdays from 8.30am to 6.50pm, except on Wednesdays when it was open from 8.30am to 12.50pm. There is a GP available 'on call' on Wednesday afternoons. Patients can ring to speak to a GP who will provide them with advice or arrange a home visit, as necessary. The latest available appointment during the week was at 6.30pm.

Reception staff showed us the appointments booking system. They could release appointments for urgent care on the day that people contacted the surgery and could also book appointments up to six weeks in advance.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Patients could access the appointments system on the phone and through the practice website. Patients could sign up to a telephone text reminder service to prompt them to attend the surgery at the right time.

Families told us, and the practice manager confirmed that children were given priority access to the GP so that they could be seen urgently, if needed. People who were unable to attend the surgery for any reason, for example because they were either at work or unable to leave their house due to illness, could also request a telephone consultation. GPs set aside time each day to make these phone calls. The GPs were also available for home visits, if they assessed this was necessary. People who potentially needed higher levels of support from their GP, for example, because they were living with a long-term health condition, were flagged on the computer appointments system so that receptionists could ensure they were given priority access to the GP. Longer appointments were available with the practice nurse for people who needed them.

The majority of the patients we spoke with, and the responses from the comment cards, indicated that people were happy with their level of access to the GP. During our inspection we observed there were a number of people attending the surgery who had been able to obtain a same day appointment. However, the results from the most recent patient survey indicated that only 59% were satisfied with surgery opening hours, which is below the national average. There was some limited feedback to suggest that people of working age found the surgery opening hours restricted their access because they were not open long enough either before or after their own working hours. The practice manager was aware of this issue and had included the need for offering longer opening hours as part of a longer-term practice development plan.

Listening and learning from concerns and complaints

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

Newly registered patients were given a practice information leaflet which included a description of how to make a complaint. Space on the practice website in the section headed 'have your say' gave information on how to make a complaint. Patients we spoke with told us they would raise concerns with the reception staff and knew they could look up how to make a formal complaint.

Reception staff told us they tried to resolve any patient concerns quickly at the time that the patient raised an issue. However, in cases where they were unable to reach a resolution they instructed people to make their complaint in writing or to speak to the practice manager directly. The verbal complaints reported to reception staff were recorded in the daily diary. However, the practice did not have a system in place to review and monitor the number and type of these concerns to identify any patterns or trends.

The practice manager showed us documents related to five formal, written complaints which had been received in the last 12 months. The practice manager told us they did not carry out a formal review of all of the complaints to identify themes as there were too few instances to review. However, we did see that each complaint had been responded to. In each case the practice manager had carried out an investigation, responded to the complainant and implemented an action plan to prevent a recurrence of the problem.

The practice manager told us she reviewed her response to any complaint with a GP to confirm that they were satisfied with the action plans that had been drawn up. She showed us minutes from one meeting where a complaint had been discussed. However, in one instance we noted a complaint related to the issuing of a prescription to the wrong person which should have been investigated as a significant event. The practice manager could not show us evidence that this had been discussed with the partner GPs and it was not recorded as a serious adverse event.

We also reviewed minutes from a recent clinical staff meeting where two complaints had been discussed with the GPs. One of the issues related to a complaint received by one of the GP partners had not been recorded in the documents given to us to review concerning recording of complaints. It is possible that the patient in this case did not make a written complaint, but a serious issue was raised. This complaint related to an inappropriate referral by a receptionist to the '111' service. The patient ultimately needed to be seen at the local accident and emergency department. This was also not recorded as a serious adverse event.

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's statement of purpose set out the practice's aim which was to provide general practice care and treatment to, and to improve the health, wellbeing and lives of, all its patients within the practice boundary of Bromley and the surrounding areas. We observed a bright, moderately spacious, caring and responsive environment. The practice was led by two GP partners. There were practice-wide objectives in place, and a plan documenting the future of service delivery. The patient interactions we observed were all positive and reassuring which reflected the culture and conduct of all staff employed within the practice. This was supported by the positive and complimentary comments received from patients during our inspection and those received within patient comment cards, but not necessarily the national GP survey.

The practice had a vision strategy and statement of purpose which outlined the practice's aims and objectives. All the staff we spoke with described the culture as supportive, open and transparent. The receptionists and all staff were friendly and approachable and were encouraged to report issues and patients' concerns to ensure those could be promptly managed.

Staff we spoke with demonstrated an awareness of the practice's purpose and were proud of their work and team. Staff felt valued and were signed up to the practice's progress and development.

Governance arrangements

The practice had good governance arrangements and an effective management structure. Appropriate policies and procedures, including human resources policies were in place. We looked at a sample of these policies which were all up to date and accessible to staff. However, locum staff had either not received a formal induction, or needed to rely on out-of-date information in induction packs. Locum clinical staff that had been utilised for longer periods were not offered formal supervision sessions.

The practice had used clinical audits to monitor quality and systems to identify where action should be taken. For example, the practice dementia audit had been carried out in October 2014 and a second cycle was repeated in January 2015. Other audits, for example, of atrial fibrillation patients, which had initially been carried out in February 2014, was in the process of being repeated to identify the impact of any changes made. However, the practice had not conducted an annual infection control audit, which was the responsibility of the full-time practice nurse, who had left the service.

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

Staff were aware of lines of accountability and who to report to. The practice had regular clinical and administrative staff meetings. Meeting minutes showed evidence of good discussions of various issues facing the practice. However, the health care assistant was not invited to attend clinical meetings and GPs did not attend administrative staff meetings and vice versa. This may have limited the effective sharing of relevant information. The practice manager was able to explain the importance of maintaining governance structures.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, the practice openly acknowledged that it was not currently conducting infection control audits so the action plan identified a training requirement for the locum nurse in infection control procedures and a need to employ a full time qualified practice nurse.

Leadership, openness and transparency

The practice was led by two GP partners. There were systems in place for monthly practice meetings which were recorded and documented. There was a clear leadership structure which had named members of staff in lead roles. For example, one GP partner was the lead for safeguarding and the other was the lead for mental health. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that practice team meetings were held regularly. Staff told us that there was an open culture

Are services well-led?

Requires improvement

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

within the practice and they had the opportunity and were happy to raise issues at team meetings. There was evidence of learning from events which the practice manager was able to show us actions and outcomes that were implemented that benefited patient care.

One of the GP partners was in the process of retiring, but agreed plans had not been shared with staff or patients. The other GP partner and practice manager provided contradictory information on the timescale for this retirement compared to the retiring GP partner, indicating some confusion amongst the leadership as to the future of the practice.

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

The practice was engaged with the Bromley Clinical Commissioning Group (CCG), the local health and care network, local hospitals and other care provider such as district nurses, health visitors and community midwife. We found the practice open to sharing, learning and engaged openly in multi-disciplinary team meetings. However, the main responsibility for attending CCG meetings lay with the practice manager, although the GP partners did also occasionally attend.

There was no Patient Participation Group (PPG) at the practice. Patients could make comments or suggestions within the practice and on the practice website. On the day of our inspection we received eight patient comment cards that had been completed in the two weeks prior to our visit. Comment cards gave a positive response about the GPs, the practice and its staff.

The practice showed us evidence that they responded to patient survey results. For example most respondents to the practice's patient survey (68%) said the last GP they saw or spoke to was good at involving them in decisions about their care. An action plan had been drawn up to require all GPs to ensure that they explained fully to patients what treatment they were proposing and explain any tests that were required so that the patients were better involved in the decision-making process.

Management lead through learning and improvement

The practice had systems and processes to ensure all staff and the practice as a whole learnt from incidents and significant events, patient surveys and complaints and, errors to ensure improvement. Staff were aware of these systems, but they were not always consistently used.

The GPs provided peer support to each other and also accessed external support to help improve care delivery.

The practice was a GP undergraduate teaching practice, taking medical students throughout their time at a local NHS Foundation Trust. Patients would be given the option to have their appointment with a student present, but only with agreement from the patient, who had the right to decline. Information informing patients of this service were displayed within the waiting area, on the practice website and in a practice information leaflet given to newly registered patients.

Staff attended courses to update their skills according to their roles and responsibilities. Staff were keen to develop their skills and further professional development with the support of the practice manager and GP partners. All staff were employed were subject to annual reviews with the practice manager.

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 17 HSCA (RA) Regulations 2014 Good governance We found that the practice did not assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. This was because the practice did not have an effective system for monitoring and responding to incidents and complaints which allowed them to evaluate and improve their practice. The practice had also not maintained accurate, complete and contemporaneous records in relation to the decisions taken following incidents or complaints. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2)(b, c and f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.