The Broomwood Road Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook

a comprehensive inspection of The Broomwood Road Surgery on 19 February 2015.

We rated The Broomwood Road Surgery overall as Good. We rated it as Good for providing safe, effective, caring and well-led services. We rated it as requires improvement for providing responsive services. We rated The Broomwood Road Surgery as Good for providing services to Older people, People with long term conditions, Families, children and young people, People whose circumstances may make them vulnerable, and People experiencing poor mental health (including people with dementia). We rated it as requires improvement for providing services to Working age people (including those recently retired and students).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed
- The practice clinical team referenced published evidence based guidance and their local clinical commissioning group care pathways in the delivery of care and treatment, and in ensuring positive health outcomes for its patients
- The practice used the Quality and Outcomes framework to measure, monitor and improve performance; and was performing better when compared to the average performances of other practices locally and nationally
- 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.

Summary of findings

- Patients said they found it difficult to get through to the practice by telephone, and that there were insufficient appointments available when they needed to see the GP.
- The practice was well led, and staff were supported with training and development. The practice made improvements in response to staff and patient feedback.

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

Importantly, the provider must:

- ensure improvements are made to the availability of appointments in the service in response to patient feedback.

In addition, the provider should:

- Ensure arrangements are in place to review urgent test results and other correspondence allocated to the practice GPs who worked part time, during the periods they were not in the practice.
- Ensure information displayed in the practice waiting area is relevant and up to date.

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 and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a robust plan to improve the availability of appointments in the service. Feedback from patients reported that they found it difficult to get through to the practice to make appointments and that appointments were not readily available. 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, there was no evidence that the practice had made sufficient changes in response to complaints, particularly complaints relating to the availability of appointments in the service.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision to promote good health outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice offered the unplanned admissions avoidance enhanced service. Patients receiving support through this service were able to call a dedicated phone line to get access to the practice. The practice worked closely with other health professionals, such as district nurses, to provide the support needed by this group of patients.

The practice carried out three monthly multi-disciplinary team meetings, which included professionals from external organisations that were involved in the care of the patients concerned.

Patients who were prescribed multiple medicines and patients prescribed repeat medicines received regular reviews. At the time of our inspection, 67% of their patients on repeat medicines had received a periodic review, and 77% of their patients prescribed four or more medicines had received a medication review.

Government guidelines recommend that flu vaccinations are offered to certain at risk groups, including people aged 65 and over, so that they are protected from the illness and developing serious complications. As of 05 January 2015, 69% of their patients aged 65 and over had received the flu vaccination for that winter season.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Longer appointments and home visits were available to patients when needed. Patients with long term conditions had a named GP and a structured annual review to check that their health and medication needs were being met.

Structured annual reviews were offered to patients with a range of long term conditions such as asthma, diabetes, epilepsy,

Summary of findings

rheumatoid arthritis and chronic obstructive pulmonary disease (COPD). The practice performance was in line with, and sometimes already exceeding, its annual targets for the management of these conditions for the year ending 31 March 2015. For example, at the time of our inspection, 88% of patients with COPD had had an annual review, which was close to their annual target of 90%; 75% of their patients with asthma had had an annual review of their asthma which included an assessment of asthma control, which had already exceed the annual target of 70%.

For those people with the most complex needs, the practice team worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice GPs and nursing team worked jointly in chronic disease management. The nurses were highly valued and undertook key roles in the monitoring and management of people with long term conditions.

Patients who were prescribed multiple medicines and patients prescribed repeat medicines received regular reviews. At the time of our inspection, 67% of their patients on repeat medicines had received a periodic review, and 77% of their patients prescribed four or more medicines had received a medication review.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013 / 14 year's performance for childhood immunisations was above the local area average for all vaccinations recommended at 12 months, 24 months and 5 years of age.

At the time of our inspection, the practice had 51% rate of uptake of Human papilloma virus (HPV) vaccine for teenage girls.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement 

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). This was because the practice did not offer sufficient appointments to meet the needs of this group.

The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group, as the appointments system was particularly difficult for them to access, due to the periodic release of appointments and the need to contact the practice at specific times to be able to book them.

However the practice offered a range of online services, including appointments booking and ordering of repeat prescriptions.

The practice offered a full range of health promotion and screening services that reflects the needs for this age group. The uptake rate for NHS Health Checks was 11% of the eligible population. At the time of our inspection, 79% of their patients in the target group had received cervical screening within the past five years; the annual target was 80%.

People whose circumstances may make them vulnerable

Good 

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.

There were 26 patients on the practice's learning disabilities register. At the time of our inspection, two of these patients had had their annual health checks. The practice manager told us that they generally carried out their annual reviews between January and March as the register must be confirmed by their LD Team. Longer appointments were provided for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good 

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

Summary of findings

There were 111 patients on the practice's mental health patients register. Of these, 69% had had a care plan agreed with them.

People experiencing poor mental health had received an annual physical health check. Records showed that 90% had a record of their blood pressure check, that 83% had a record of their alcohol consumption, and that 78% of the patients who had lithium therapy had had the recommended blood tests as part of their dosage review.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice had an in-house counsellor, which patients were able to access once referred through the Improving Access to Psychological Therapies (IAPT) programme. The IAPT is an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders.

Summary of findings

What people who use the service say

We spoke with three patients during our inspection. The practice had a patient participation group (PPG) and we spoke with one member of the group. We also received completed CQC comment cards from 22 patients.

The feedback we received about the practice were positive about the standards of care and treatment provided and the feedback was complimentary about the staff team. Patients we spoke with told us the staff were kind to them, and that they received due care and attention when they visited the practice for treatment.

Nineteen of the completed CQC comments cards we received were entirely positive. However a few of the patients we spoke with or who completed comments cards raised concerns about difficulties they had accessing the practice and getting appointments. Patients told us they had difficulties getting through on the phone, that there was a lack of available appointments in general, and that appointments were only made available at specific times and were quickly booked up.

The latest GP patient survey results (published on 08 January 2015) found that 67% of respondents would probably or definitely recommend the practice to someone who had just moved to the area, and that 73% of respondents rated their experience of the practice as fairly good or very good. These results were lower than the local area and national averages for these questions.

The latest results of the NHS friends and family test showed that 51% of respondents were extremely likely, and 32% were likely, to recommend the practice to someone new to the area.

Areas for improvement

Action the service MUST take to improve

The practice must ensure improvements are made to the availability of appointments in the service in response to patient feedback.

Action the service SHOULD take to improve

Ensure arrangements are in place to review urgent test results and other correspondence allocated to the practice GPs who worked part time, during the periods they are not in the practice.

Ensure information displayed in the practice waiting area is relevant and up to date.

The Broomwood Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor and a practice management specialist advisor. They are granted the same authority to enter the registered persons' premises as the CQC inspectors.

Background to The Broomwood Road Surgery

The Broomwood Road Surgery is located in St Pauls Cray in Orpington Kent. At the time of our inspection, the practice had 10015 registered patients. The practice is a member of the Bromley clinical commissioning group (CCG).

The demographics of the practice population were similar to that of average practices across England in terms of age distribution. Young people, aged 18 and under, make up 38% of the practice population (the average across England is 32%). Those aged over 65 make up 15.7% (England average is 16.7%), and the remainder of the practice population were of typical working age, between 18 and 65, and make up 46.3% of the practice population.

The deprivation (IMD) score for the local area is 32.9, and the practice is located in an area ranked in the third more deprived decile in the country. People living in more deprived areas tend to have a greater need for health services.

The staff team consist of four GP partners one of whom is male, three salaried GPs one of whom is female, two female nurses, one female healthcare assistant, a practice manager, a deputy practice manager, a reception manager and a team of administrative and reception staff. Two of the salaried GPs and one of the practice partners were full time, whilst the rest of the partners and GP are part time.

The Broomwood Road Surgery is a training practice. At the time of our inspection there was one GP registrar being trained at the practice.

The Broomwood Road Surgery is registered with the Care Quality Commission (CQC) to carry on the regulated activities of Diagnostic and screening procedures, Family planning services, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The practice provides general practice services under a General Medical Services (GMS) contract.

When the surgery registered with the CQC, the provider declared itself non-compliant with standards relating to the safety and suitability of premises, and standards relating to cleanliness and infection control.

Doctor appointments were available Mondays to Fridays between 8:30am and 12:00 pm, then between 3:00pm - 6:00pm, with the exception of Thursdays when appointments were only available between 8:30am - 12:00 pm. The practice closed at lunchtimes between 12.30pm and 1.30pm. The surgery was open daily from 8:00am to 6:00pm , with the exception of Thursdays when it closed at 12:30pm

The practice has opted out of providing out-of-hours services to their own patients. When the practice was closed, patients were directed to the out of hours provider, ENDOC, via NHS 111.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them.

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 and asked other organisations to share what they knew.

We carried out an announced visit on 19 February 2015. During our visit we spoke with a range of staff (GPs, nurse, healthcare assistant, administrative and reception staff and the practice management team) and spoke with patients who used the service.

We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, following an incident where the practice experienced temporary loss of network access on their computer system, they carried out a business continuity test under their information governance framework. This led them to review and make improvements to their processes. They started to back up the appointment system each night on a memory stick.

We reviewed incident reports and minutes of meetings where incidents were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events was a standing item at the monthly practice staff meeting agenda and a dedicated meeting was held fortnightly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example following an incident where a patient had gained access into a staff only area and threatened staff, the safety and security arrangements had been reviewed and updated to ensure safety of staff and premises.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the clinical team and practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical and where appropriate at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. GPs had received level three training in child protection, nurses had level two, and the remaining staff had level one training. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for the local authority safeguarding teams were easily accessible to the practice team, via their electronic records system, and the contact details were also displayed in all consultation rooms.

The practice had a safeguarding policy, kept reviewed and updated, which was available to all staff electronically on shared computer drives. All staff we spoke with were aware of how to access this policy.

The practice had appointed two dedicated GPs, who shared the role as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a chaperone policy in place, and the outside of all consultation room doors had notices informing patients that they could request a chaperone to be present during their consultation. (A chaperone is a person who acts as a

safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff did not act as chaperones in the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

The practice took a multi-disciplinary approach in the case management of vulnerable children. The practice held bi-monthly meetings to discuss child protection cases. The meetings were attended by the GP leads for safeguarding, the led practice nurse, a school nurse, health visitor and midwife. Whilst he practice GPs were not routinely able to attend child protection case conferences with social services, they submitted written reports to inform the case conference discussions.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of a practice meeting that noted the actions taken in response to the cold chain being broken for medicines that required refrigeration. The incident was discussed and appropriate actions had been taken to address it. A flowchart was in place at the time of our inspection which clearly outlined to staff the actions they needed to take if the temperature at which medicines were stored went out of range.

We saw records that showed the practice's stock of vaccines were audited.

No controlled drugs were held in the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Patients were able to be transferred to the prescription clerks directly if they had a telephone query about their prescriptions.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection prevention and control (IPC) who had undertaken further training to enable them to provide advice on the practice IPC policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. Reception staff had received training in how to handle samples brought in by patients, and had a policy available to them in the reception area to reference. All staff were offered the Hepatitis B vaccination.

Annual IPC audits were conducted in the practice. Staff meeting minutes showed that the findings of the audits were discussed.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's IPC policy. There was also a policy for needle stick injury, which was displayed in the consultation and treatment rooms, and staff knew the procedure to follow in the event of such an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice contracted a cleaning company to carry out domestic cleaning of the premises. We saw certificates, dated 17 February 2015, indicating that the cleaning staff had received IPC training. We saw there were cleaning schedules and procedures in place and cleaning records were kept. The practice management told us that their clinical commissioning group (CCG) had shared their cleaning procedures with other practices in the local area as an example of comprehensive cleaning methods.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice were carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in September 2014.

The practice had two consultation rooms that were dedicated for use for the treatment of patients who had particularly infectious illnesses, to help minimise the spread of certain infections.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, 18 December 2014.

A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the medicines fridge thermometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Clinical staff were subject to DBS checks, however non-clinical staff were not checked. The practice had completed a risk assessment to support their decision not to carry out DBS checks for non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's absences such as during periods of annual leave.

The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. A demand audit had been carried out to inform staffing needs, but had not been recently repeated in response to concerns raised by patients about accessing the service.

The practice administrative team was based on the upper level away from the clinical areas. The administrative team included two prescription clerks and two secretaries. An additional secretary had been recruited and was due to join the practice in March 2015.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual equipment checks, checks on the environment, medicines management, staffing, dealing with emergencies and equipment. The practice 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. The practice manager carried out regular walk rounds of the building to ensure there were suitable health and safety arrangements in place. However these were not documented.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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

Protocols on how to deal with medical emergencies, such as if a patient collapsed, were available to staff and located in the reception area.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan had been recently reviewed, in December 2014. The business continuity plan was available to all staff via the shared computer drive and via email. A hard copy was also located in the reception area. The business continuity plan had in place arrangements to respond to adverse weather, utility services incidents and power outages.

We saw a report of an audit that had been carried out on the effectiveness of the business continuity arrangements following a computer outage in December 2014. Learning points were actioned and there was feedback provided to all staff at the practice team meeting.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. The practice staff team practised fire drills twice a year. The practice management team told us that the practice had held a fire drill on 18 February 2015, as they had five new members of staff. Procedures to follow in the event of a fire were displayed in the practice. Fire exits were clearly signed, and fire extinguishers were in place. Records showed the fire extinguishers had been checked and maintained on 29 October 2014.

Risks associated with service and staffing changes (both planned and unplanned) were managed by the practice management team. For example staffing shortages were managed by the reception manager for the reception staff, by the practice manager and their deputy for GPs and administrative staff cover.

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. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice provided us with their latest quarterly performance dashboard from their local (Bromley) Clinical Commissioning Group (CCG). Bromley CCG produces a quarterly dashboard to all practices. The dashboard looks at referral rates for all GP referred outpatient attendances (where the patient attended and was seen) for all specialties, including general medicine, cardiology, dermatology, gynaecology and musculoskeletal disorders (MSK).

The Broomwood road surgery referral rates were in line with referral rates for the area to secondary and other community care services for all conditions. However the data showed that the practice referral rates were particularly high for dermatology and gynaecology, but lower for musculoskeletal disorders.

The dashboard also looked at discharges after first attendances for all specialities, and we saw that the figures for the practice were similar to the average for the CCG area.

The practice maintained disease registers for the major diseases, as reportable under the Quality and Outcomes framework (QOF). Data from the CCG performance dashboard showed that the rates of diseases among the practice population were similar to other practices in the local area for most diseases.

All GPs we spoke with used national standards and local clinical pathways for the referrals to speciality medical services. For example, patients with suspected cancers were referred and seen within two weeks.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us various clinical audits that had been undertaken in recent years. One audit reviewed the care provided to patients with heart failure. The first cycle found that 71 patients met the audit criteria for inclusion. The audit reviewed the treatment provided to these patients, whether it was optimal and in line with the NICE guidelines for the diagnosis and management of chronic heart failure in primary and secondary care (2010). A second part to the audit also reviewed the treatment provided to patients at risk of heart failure.

A second audit we saw related to mental health care plans, to ensure suitable care plans were in place for patients on the mental health register. The first cycle of the audit was carried out between January and April 2014 and found that 82% of eligible patients had care plans in place. A series of recommendations were made following this first cycle of

the audit including maintaining an up to date register of patients with mental health, quarterly reviews of mental health plans, and carrying out mental health plan reviews with the patients when they attend the practice for a medication review. The practice planned to re-audit the care plans in a year's time.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance, and that medicines were being prescribed in line with recommended guidelines.

The practice GPs told us that clinical audits were discussed at clinical meetings throughout the year, and we saw meeting minutes in support of this. For example at a recent meeting the findings of a prescribing audit had been discussed and resulting improvement actions communicated.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and 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). For example, we saw an audit regarding the prescribing of a medicine recommended as a possible treatment for adults with primary hypercholesterolaemia. New guidelines, based on evidence taken from a large study of patients, found important information which concluded that other medicines were much better at lowering the fat levels and preventing heart attacks and strokes. Patients were being contacted and invited for a medication review to discuss the possibilities of changing their medicines if it was appropriate for them to do so.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 86% of patients on their asthma register had had an asthma review in the preceding 12 months that included an assessment of asthma control. The practice met all the minimum standards for QOF in asthma, epilepsy, heart failure, hyperthyroidism and rheumatoid arthritis. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had a good understanding of best treatment for each patient's needs.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, infection prevention and control, safeguarding and information governance.

We noted a good skill mix among the doctors with additional diplomas gained among them including obstetrics and gynaecology, family planning, and diplomas in child health. 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).

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the healthcare assistant was being supported to study for the Certificate of Higher Education in Healthcare Practice. The healthcare assistant told us they had plans to go on to study to become a nurse. The healthcare assistant carried out reviews of patients with dementia, and provided the in-house smoking cessation service; and had received appropriate training to enable them to carry out these duties.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

The nursing team performed defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they had received training in administration of vaccines and in cervical cytology. Those with extended roles, such as reviewing patients with long-term conditions including asthma, and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, and information from the out-of-hours GP service and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. Some of the practice GPs worked part time, and we found there were no arrangements to ensure results allocated to them were seen promptly if there were not in the practice over a number of days. However at the time of our inspection, we found there were no backlog of results that had not been reviewed and actioned.

The practice was commissioned for the avoiding unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy to action hospital communications was working well in this respect. The practice undertook a yearly audit of patients they followed up to ensure that they had been monitored appropriately.

The practice held quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice partners rotated attendance at the local CCG cluster meetings. The key discussion points from these meetings were then fed back and discussed at practice clinical meetings.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (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). Staff reported that this system was easy to use.

The practice had signed up to a shared electronic patient record system. This provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved

Good

Are services effective?

(for example, treatment is effective)

in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. 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 practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention of ill health

There was a self-use health monitor machine available in the practice waiting area. Patients were able to check their own height and weight, which the machine used to calculate their body mass index, and they could also take their blood pressure readings. The machine printed individual patient results as well as information about healthy measurements for body mass index and blood pressure. We saw that staff asked patients not to stand in front of the health monitor machine to allow those using it some privacy.

There was a range of health promotion, health information and practice information available for patients in the practice waiting area. This included information such as health and community based support services, health screening programmes, patient participation group activities, as well as practical information such as cancelling appointments.

We saw that some of the information displayed was out of date, such as the practice approval to deliver sexual health services was dated April 2010 to March 2013.

It was practice policy to offer a health check with the health care assistant practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40 to 74 years. At the time of our inspection, the uptake rate for NHS Health Checks was 11% of the eligible population.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and two of the 26 patients on the register had received an annual physical health check. The practice manager told us that they generally carried out their annual reviews between January and March as the register must be confirmed by their LD Team.

The practice's performance for cervical screening uptake was 79%, which was close to achieving its annual target of 80% for the year ending 31 March 2015. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw that the GPs came out into the waiting area and called patients in for their appointments.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey (published on 08 January 2015, and which contain aggregated data collected from January-March 2014 and July-September 2014), a survey of 367 patients undertaken by the practice with input from its Patient Participation Group (PPG) during the 2013 /14 year, and results from the NHS friends and family test (FFT). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, data from the GP patient survey showed 81% of respondents felt the GP treated them with care and concern and the same proportion felt the GP gave them enough time, which were similar to the local average scores of 82% and 83% respectively. The practice was also similar to the local area average for the proportion of practice respondents saying the GP was good at listening to them; the practice score was 85% whilst the local area average was 86%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive and the less favourable comments related to difficulties patients had accessing the service. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The latest practice survey conducted between December 2013 and January 2014 was focussed on exploring ways that the practice could improve patient access. Patients were asked questions relating to their use of the services at the practice, asked about additional services they would to see provided in the practice.

The latest results of the NHS friends and family test showed that 51% of respondents were extremely likely, and 32% were likely, to recommend the practice to someone new to the area.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Although the practice switchboard was located at the reception desk area, and telephone calls were answered at the reception desk, there was a screened off area which was kept closed to minimise conversations being overheard. However conversations could still be overheard between staff. We did not hear confidential information being discussed by staff in this area.

We saw that staff in the reception area spoke respectfully to patients. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 72.3% of practice respondents said the GP involved them in care decisions, and 78% felt the GP was good at explaining treatment and results. Both these results were similar to the local area and national average results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Feedback from the patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the television screen and practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, they were sent a condolence card. All staff were informed of cases of bereavement among patients, so they were able to offer their condolences, particularly if the bereaved was well known to them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice had systems in place to respond to patients' needs. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). They conducted their annual patient survey in conjunction with their PPG and agreed with them the actions they would take in response to the results.

The practice actively publicised its PPG through notices in the waiting area and a dedicated area on their website.

The results of patient surveys were displayed in the waiting area, along with details of actions they practice was taking to address any issues raised.

The latest practice survey results showed that most respondents, 89%, had access to a mobile phone, and 78% would value a text message reminder about their appointment 24 hours in advance. Many respondents, 68%, also said they would value being able to cancel appointments via text message and 70% said they would be happy to receive other information from the practice via text message. Email was reported by highest proportion of respondents, 47%, as the alternative means they would like to be able to consult with a GP. In response to the survey results, the practice was investigating adjustments they could make to the appointments system.

Tackling inequity and promoting equality

The practice had eight GP consultation rooms and three nurse treatment rooms, two of which were on the upper level of the building. There were two consultation rooms reserved for treatment of patients with specific infection control requirements.

There was one disabled parking space in the car park to the front of the practice premises, with the rest of the parking spaces reserved for staff use.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had access to telephone translation services. The practice management team also told us that they had had the need to use face to face interpreters more frequently in recent years, as more people who had settled in the area and registered with the practice were non-English speaking. There were no additional languages spoken by the staff team in the practice. There was an option to translate the practice website content into other languages.

There was no lift access between the ground and first floors in the practice. The practice management team told us they were limited by building constraints to the level of adjustments that were possible in the building. The premises were therefore not fully adapted to meet the needs of people with disabilities. Patients who were unable to use the stairs were provided with appointments in consultation rooms on the ground floor.

Access to the service

New patients registering were only able to submit their applications at a certain time of the day, during the early afternoon. The practice had received patient feedback that this restriction was difficult and impractical for them due to other commitments, such as for those of working age.

Details about the practice opening hours were available on their website and in the practice leaflet. Doctor appointments were available Mondays to Fridays between 8:30am and 12:00 pm, then between 3:00pm - 6:00pm, with the exception of Thursdays when appointments were only available between 8:30am - 12:00 pm. The practice closed at lunchtimes between 12.30pm and 1.30pm. When the practice was closed patients were asked to call 111 for medical attention, or 999 for medical emergencies.

Information about other times when the practice was closed was available on the website, such as for academic training half days for the doctors.

Patients attending the practice for their appointments were able to check in via and electronic terminal in the waiting area.

The practice operated a periodic release appointments system. Appointments were made available for a few days

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

in advance. The practice recognised that as not all their GPs were full time, they were not able to routinely offer patients appointments with a GP of their choice. The practice offered telephone consultations with GPs The practice management team told us they had visited another practice, with a similar profile to theirs, to review their appointments system with a view of implementing a system that worked better for their patients.

As from the 1st July 2014, the practice no longer offered extended hours. These were previously available as booked appointments on Thursday evenings and Saturday mornings. The practice management team told us that when they did offer extended hours, appointments during those periods were not made by their targeted patients, which were commuters. They also told us they experienced a lot of non-attendance at these appointments which led to the service becoming financially unviable.

The practice management team explained to us that they had particular challenges with patients not attending their booked appointments. To address this issue, they offered patients different ways of cancelling appointments, such as by their dedicated phone line for cancellations, in person and online if they were registered to use online services. The practice had a policy regarding non-attendees at appointments. This included sending letters after repeated missed appointments, and in extreme cases removing the patient and possibly their family members, from the patient list. We spoke with them about considering amending their policy in particular whether they it was appropriate to remove family members from their patient list.

Patients had given feedback through various sources, surveys, comments and complaints, that they had difficulties accessing the service and getting appointments when they needed them. The practice had introduced different services such as online services and telephone consultations to try and reduce the access issues.

Registered patients were able to book and cancel appointments and order repeat prescriptions through the practice website. Telephone consultations were available with a GP daily.

The practice had an admissions avoidance direct contact telephone line. This service was for patients on the register of those at risk of unplanned admissions to hospital. When these patients called a dedicated phone number they were able to access their care coordinator directly to discuss their needs, and arrange any additional care and support they needed.

Listening and learning from concerns and complaints

The practice has 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 there was a designated responsible person who handled all complaints in the practice.

We saw that information was available, in the form of a complaints leaflet and information on the practice website, to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 26 complaints received between April 2014 and January 2015. We found they had been satisfactorily handled, and dealt with in a timely way. The practice had dealt with complaints with openness and transparency. Lessons learned from individual complaints had been acted on.

The complaints we reviewed showed that the themes to the complaints mainly related to patients being unsatisfied with the care they received, and to a lesser extent being unhappy with the difficulties they had accessing the service.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose.

The practice team included team members that had been working in the practice for many years. For example the senior partner and the practice manager had been working in the practice for more than 20 years.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures and saw that they were kept up to date and made available for the staff team.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control; two of the GPs were the safeguarding leads, and there were GP leads for key areas of clinical practice such as orthopaedics, haematology and dermatology. We spoke with a range of staff during our inspection, including GPs, nursing staff, administration and reception staff, and we found 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.

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. For the 2013 /14 year the practice had achieved an overall QOF score of 91.8%, which was similar to local and national averages. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. They had undertaken recent audits in various areas of clinical practice including prescribing, management of patients with heart failure and care planning for patients with mental health needs.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice team met informally for lunch together daily.

The practice manager was responsible for human resources policies and procedures. We reviewed a number of the human resources policies, for example the recruitment policy and procedures, induction policy, and the whistleblowing policy, which were in place to support staff. These documents were stored electronically and made available to the team.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints. We looked at the results of the latest practice survey which found that 80% of respondents would like other ways of consulting with GP in addition to face to face consultations. We saw as a result of this the practice had introduced telephone consultation appointments. We reviewed a report on comments from patients received between April 2014 and January 2015. The complaints we reviewed showed that the themes to the complaints mainly related to patients being unsatisfied with the care they received, and to a lesser extent being unhappy with the difficulties they had accessing the service.

The practice had a patient participation group (PPG), and was actively trying to recruit into the group so that it was more reflective of the various population groups registered with the practice. The PPG worked with the practice in the development and running of the annual practice survey, prior to the introduction of the NHS friends and family test.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they

Are services well-led?

Good

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. We saw that the policy was periodically reviewed, and had been most recently reviewed in January 2015.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. The practice was a GP training practice.

The clinical team attended the academic half days organised by the local clinical commissioning group (CCG), which took place every two to three months. The GPs were given the time to attend these sessions, and the practice was closed during this time.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.

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 **The provider did not ensure that systems were in place to improve the quality of the services provided and the quality of the experience of service users in receiving those services); and did not act on feedback from relevant persons and other persons on the services provided.** **This was because the provider had not ensured improvements were made to the accessibility of the service in response to patient feedback. This is in breach of regulation 17 (2)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**