Hildenborough and Tonbridge Medical Group

Quality Report

Hildenborough & Tonbridge Medical Group
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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.

Summary of findings

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Summary of findings

Overall summary

Hildenborough & Tonbridge Medical Group is a GP practice providing primary care services for people in Hildenborough, Kent and the surrounding area. It is a large practice with multiple partners and provides primary care services for about 16,500 people. There are two main surgery sites, Hildenborough Medical Centre and Trenchwood Medical Centre. There are also branch surgeries in the nearby villages of Leigh and Weald, but we did not visit these as part of this inspection.

As part of the inspection we talked with the local Clinical Commissioning Group, the local Healthwatch, members of the Patient Participation Group, patients who were at the Hildenborough Medical Centre on the day of the inspection, GPs, doctors, clinical staff and administrative staff at the practice.

Patients we spoke with were very satisfied with the care they had received and told us that they felt involved in their care. They felt their medical issues were taken seriously and that they had sufficient time during their appointments. The recent patient survey reflected this view. However the patient survey showed that 35% of patients did not find it easy to get through to reception on the telephone. Patients said that they could always get an urgent appointment when it was required.

We saw an effective system was in place to learn from significant events. There were processes in place to protect people from abuse. Clinical audit was carried out across a range of activities and staff were aware of the importance of working with other services. Although concern was raised about accessing the practice via telephone in the morning, all of the patients we spoke with were complimentary about the care they received from the practice and we observed that staff were caring. We saw that there was evidence of a strong clinical governance that ensured the practice learnt from events and patient feedback.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe. We saw that arrangements were in place to ensure safe patient care.

There was an effective system in place to learn from significant events, accidents or incidents. Safeguarding procedures were in place to ensure patients were safeguarded against the risk of abuse. We found there were appropriate arrangements in place for managing medicines. The practice was clean and there were effective systems in place to minimise the risk of healthcare associated infection.

Are services effective?
The service was effective. There was evidence of clinical audit across a range of activity. Care and treatment was delivered in line with best practice guidelines. There was an overarching training plan for staff. QOF results for the practice showed that it achieved high scores in areas related to providing effective treatment for patients.

Staff were aware of the importance of working with other services to achieve the best outcomes for patients. There was a wide choice of health promotion material both on paper and web based.

Are services caring?
The service was caring. All of the patients we spoke with or who provided feedback were complimentary about the care they had received. We saw and heard staff were caring, compassionate and empathetic.

Patients said that they had enough information and time with the GP or nurse to meet their needs and that treatment was explained to them.

Are services responsive to people's needs?
The service was responsive. There was an active and effective patient participation group. There was a clear complaints policy. Comments and complaints were acted upon to improve the service.

Patients were concerned about the difficulty getting through on the telephone in the morning.

Are services well-led?
Overall the service was well led. There was a strong structure and staff were clear about their accountabilities. There was an open and supportive culture.

Summary of findings

There were audits and risk management tools in place in place to ensure the safety of patients, staff and visitors. There was strong clinical governance, which ensured that lessons were learned at the appropriate levels within the organisation. The practice recognised strategic risks and had plans in place to mitigate them.

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
Older people represented a large part of the general practice population. Older people were cared for as part of the practice's patient-centred approach, which focused on individuals' needs and preferences

People with long-term conditions
People with long term conditions were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. There were specialist clinics and GPs with specialities to address the needs of people with long term conditions

Mothers, babies, children and young people
Mothers, babies, children and young patients were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. There were midwifery clinics and a school nurse service

The working-age population and those recently retired
Working age patients were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences

People in vulnerable circumstances who may have poor access to primary care
Patients in vulnerable circumstances were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences

People experiencing poor mental health
Patients experiencing poor mental health were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences

Summary of findings

What people who use the service say

The recent survey results (2013 GP Patient Surveys) showed that the proportion of patients using this service who would recommend their GP practice and the percentage of patients rating their practice as good or very good were 90% and 95% respectively. This places the practice as "among the best" in this regard.

The issue of poor telephone access was highlighted in the survey with only 57% of patients rating their ability to get through on the phone as very easy or easy. This places the practice as among the worst in this regard.

NHS Choices is an online facility which allows people to comment on their experiences on NHS services. There were four comments made between July 2012 and April 2014. One was negative and concerned the telephone system. Three were positive. They mentioned the caring approach of doctors, professionalism and involvement in care. The management were singled out for being efficient, professional and considerate in a case involving palliative care.

We spoke with 11 patients who were at the Westwood surgery on the day of the inspection. We received no comments from patients on the comments cards that we provided but the practice only received these the day before the inspection.

Patients told us that it was sometimes difficult to get through on the telephone. However, they also said that when they did get through, they were able to make an appointment on the day of their choice. Patients who needed to get an appointment the same day were able to do so. Patients said that they appreciated having a doctor dedicated to a daily surgery because it meant they could be seen on the day they telephoned if the matter was pressing.

Patients described the service as friendly, efficient and professional. They said that they were seen near to or at the time of their appointment. Patients said that their health and care needs were discussed. GPs and nurses explained the various treatment options and decisions about treatment were made in collaboration with health professionals. Patients said that they were treated with respect. They said that their dignity and confidentiality were respected. No patients we spoke with had made a complaint but they felt that if they did have cause to complain the staff would listen to what they had to say. No patients made any negative comments apart from those related to getting through on the telephone.

Areas for improvement

Action the service COULD take to improve

- Ensure that all staff appraisals are kept up to date
- Review all policies to ensure they are current and correct.
- Improve the telephone service to reduce the time spent by patients queuing for an answer, predominantly early in the morning.

Hildenborough and Tonbridge Medical GroupHildenborough & Tonbridge Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector, a general practitioner, a specialist advisor in clinical governance and an expert by experience.

Background to Hildenborough and Tonbridge Medical Group

Hildenborough & Tonbridge Medical Group is a GP practice providing primary care services for people in Hildenborough, Kent and the surrounding area. It is a large practice with multiple partners and provides primary care services for about 16,500 people.

There are two main surgery sites:

the Hildenborough Medical Centre in Hildebnborough and the Trenchwood Medical Centre in Tonbridge.

There are also two branch surgeries in nearby villages namely Leigh Surgery in Leigh and Weald Surgery in Weald, Kent.

There are 10 partners in the practice, one of whom is the practice manager. The practice provides a full range of GP services. For example, there were child health, midwifery and minor operations clinics. In addition there were specialist clinics such as anticoagulant monitoring, asthma, coronary heart disease and diabetes.

The practice is approved for training GPs and has registrars working at the practice. Registrars are qualified doctors who are training to be GPs.

The general demographics were typical of this part of the South East of England. For example, there is a higher percentage of the practice population aged 65 and over and a higher percentage in the 18 and younger age group.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining "good practice" in their surgeries.

We asked the local Clinical Commissioning Group and the local Healthwatch to share what they knew about the service.

The visit was announced on the practice website and people were asked to send their comments to the CQC lead inspector whose e-mail address was provided. We placed comment cards in the surgery reception so that patients could share their views and experiences of the service before, during and after the inspection visit.

We carried out an announced inspection on 15 May 2014. During the inspection we spoke with a range of staff. This included general practitioners (GPs), registered nurses and healthcare assistants, receptionists, the practice manager and deputy practice manager and other administration staff. We spoke with patients, with carers and/or family members.

Are services safe?

Summary of findings

Overall the service was safe. We saw that arrangements were in place to ensure safe patient care.

There was an effective system in place to learn from significant events, accidents or incidents. Safeguarding procedures were in place to ensure patients were safeguarded against the risk of abuse. We found there were appropriate arrangements in place for managing medicines. The practice was clean and there were effective systems in place to minimise the risk of healthcare associated infection.

Our findings

Safe Patient Care

Staff described a significant event to us which involved a letter about a patient that had been received into a registrar's electronic mailbox just after they had left the practice. There had been a delay in reading this letter and acting on the advice because no one had checked the mailbox. After a full investigation and review, the conclusion and recommendation was that when a registrar leaves the practice, their mailbox should be closed immediately thus preventing a recurrence. This showed there were effective arrangements in place for reporting safety incidents.

There were regular clinical reviews in the practice such as reviews of patients who frequently attended the Emergency Department of the local hospital. The review focused on the issues that might have caused the admission. The GPs then considered what other services might be deployed, for example the enablement at home service, which could reduce the likelihood of future admissions. The GPs and other doctors reviewed cases where they had clinical problems and discussed different ways of approaching the issues. This minimised the potential for error and allowed GPs and other doctors to consider whether their approaches to problems were reflecting national and professional guidance.

Learning from Incidents

We saw evidence that staff were aware of the process for reporting significant events and knew who to refer to. For example when we spoke to staff in the pharmacy they told us of the two named GPs to whom they were to refer incidents. One of the named GPs had previously trained as a pharmacist. This meant that that GP was able to apply specialist knowledge in reviewing the significance of an event.

We looked at the significant event process. The practice used a printed pro-forma. This was completed by the individual (any member of staff including GPs, nurses and administration staff). The GPs discussed these whenever they arose and at least weekly at their informal meetings, and formally at their monthly meeting. There was also a meeting for dispensing staff every other month and dispensing significant events were discussed there. Conclusions and actions were then disseminated to the

Are services safe?

relevant staff by a monthly staff newsletter and at the staff meetings. We saw that this was effective because staff told us of changes they had made to their practice as a result of what they had learned at staff meetings.

We saw evidence of learning from mistakes. The practice had identified an issue with immunisations (vaccines). Stock that had been out of date had been inadvertently given to patients. This was fully investigated and the results shared with the commissioners. A programme of re-immunisation had been completed. Where appropriate, staff had been disciplined as they had not been checking the expiry date as per the policy. In another incident a patient had collapsed in the waiting room. A review of the incident had identified issues regarding access to the emergency equipment and the patient's privacy. As a result the waiting area had been modified to provide more privacy and the emergency equipment had been moved to a place that was more easily accessible to all of the staff.

Safeguarding

There were GP partner leads for both adult and child safeguarding who had been trained to the appropriate level. All staff had had up-to-date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral. Although we noted that the policies were not dated, we saw that the information was relevant and current. All the staff we spoke with were aware of who the safeguarding leads were and how to make a referral. There were posters on display giving the contact details, for safeguarding, of Kent County Council. Staff described an adult safeguarding referral in relation to concerns that a patient appeared to be the victim of financial coercion. The practice made a safeguarding referral, which was investigated, with advice given to the practice.

Monitoring Safety & Responding to Risk

We saw that staffing establishments were set and reviewed. For example as well as the GPs, doctors and nurses employed at the practice there were other team members attached to the practice. These included school nurses, counsellors, health visitors and hospice nurses. This meant that there was a range of services available to keep patients safe and meet their needs.

The staffing levels and skill-mix was managed to support safe, effective and compassionate care. For example staff worked flexibly to administer influenza vaccinations during busy periods. There was a doctor available each day to deal with urgent appointments. There was a doctor allocated to deal with any emergencies that might happen within the practice or to patients of the practice in their homes nearby.

We discussed with a GP an incident when a patient collapsed in the waiting room with a cardiac arrest. The ambulance service responded as an emergency and life support was initiated. After defibrillation, and the patient was stabilised before being admitted to the local hospital. The patient survived and their wife had contacted the practice to thank the staff for their actions. This emergency had demonstrated that up-to-date emergency equipment and drugs were available and that trained and competent staff were available to use them. After a review of the incident, the emergency equipment was moved to a more practical location in the reception area, flat sided scissors were included in the emergency kit so that patients' undergarments could be removed with less risk of damaging their skin and towels were included to dry patients' skin before applying defibrillation.

Medicines Management

There was a comprehensive range of standard operating procedures (SOPs) contained in a loose-leaf file readily available for reference in the dispensary. These included SOPs for equipment, hygiene, ordering and stock control, dispensing prescribed and controlled drugs (CD), repeat prescriptions and checking dispensed items. There was a systematic approach to managing the risks associated with medicines. For example the stock control system made it less likely that out of date medicines would be dispensed. The system for checking dispensed items meant that the likelihood of a person receiving the wrong medicines was reduced.

The locked controlled drugs cupboard was kept in a separate locked room. This meant that medicines deemed particularly hazardous were subject to increased security. There were also two pharmacy fridges. Drugs requiring storage at below 4 Celsius were stored in one fridge and immunisation stock for use by the clinicians were stored in a second. Fridge temperatures were frequently checked and recorded to ensure that medicines and vaccines were kept at the right temperature range.

Cleanliness & Infection Control

The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with ample personal protective equipment including a range of disposable

gloves, aprons and coverings. This enabled health care professionals to follow aseptic techniques. We saw that antibacterial gel was available in the reception area for people to use and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the building. We saw that all instruments were single use only. This meant the risk of cross infection was reduced.

We saw that there was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company. There were cleaning schedules in place and we saw there was a supply of approved cleaning products. Treatment rooms were fitted with hard flooring so spillages were easily cleared up. A person was employed to clean the premises daily. This meant that people were treated and cared for in a clean hygienic environment.

Dealing with Emergencies

There was an on-call system of three shifts during the day when one of the GPs on duty was nominated to deal with all emergency situations. The nominated doctor was shown on a display board that was visible to the reception staff. This meant that staff would always know who to contact in the event of a medical emergency. The system had been tested in an emergency and worked. There were plans in place for contingencies such as bad weather. The practice had two large sites, Westwood and Trenchwood surgeries, and there were plans in place to relocate one surgery to the other if there was a major event, such as fire.

Equipment

We looked at the emergency medicines and equipment available. The range was adequate to meet the kind of emergencies that were likely in the practice and was consistent with the guidelines issued by the Resuscitation Council (UK). There was an automated external defibrillator (AED) and all staff were trained in its use. The policy dictated that the medicines and equipment should be checked monthly to ensure that the equipment was fit for purpose and the medicines were in date. We saw that this had been done and results recorded. This meant that the equipment and medicines available were suitable to the kinds of emergencies that were likely to be met in primary care situations.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective. There was evidence of clinical audit across a range of activity. Care and treatment was delivered in line with best practice guidelines. There was an overarching training plan for all staff.

Staff were aware of the importance of working with other services to achieve the best outcomes for patients. There was a wide choice of health promotion material both on paper and web-based.

Our findings

Promoting Best Practice

We saw several examples where care and treatment followed national best practice and guidelines. For example, the emergency medicines and equipment held by the practice was consistent with the guidelines issued by the Resuscitation Council (UK). The practice used the National Institute for Health and Care Excellence (NICE) guidance. This was incorporated into local guidelines and care pathways and these included falls prevention, treatment of cellulitis and deep vein thrombosis. This demonstrated that the practice had a systematic approach to following and staying up to date with recognised best practice.

The practice used the quality and outcomes framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The QOF data for this practice showed that it generally achieved high or very high scores in areas that reflected on the effectiveness of care. For example the practice had consistently exceeded the national and local standards in the field of care for patients experiencing a mental health problem. Whereas the national performance across some of the relevant QOF indicators had been in the area 80% - 89% the practice was achieving 95% - 98% across the same indicators.

The practice had recently received notification from the medicines management team concerning the high use of specific broad-spectrum antibacterial drugs. The GPs reviewed, and changed, their practice. A recent audit completed, after the changes, had shown that the practice had made progress in all the areas for improvement suggested by the medicines management team. This showed the practice was responsive to alerts about their use of medicines.

Management, monitoring and improving outcomes for people

The practice had recently carried out a clinical audit to review all Type 1 diabetics (these are people who have to use Insulin to control their diabetes) to see if they had had a recent blood test (Glycosylated Haemoglobin – HbA1c) as recommended for monitoring their blood sugar control. The results are then developed into evaluating whether patients had had assessments in line with NICE guidance.

Are services effective?

(for example, treatment is effective)

As most patients attended the local hospital, this involved reviewing the letters and information that had been extracted from the letters. The hospital was involved to confirm their data. It was found that the practice had missed recording some data and that not all assessments had been performed at the hospital. As a result of this work the practice now reviewed all these patients themselves. This meant that whereas before some patients had missed assessments, now this was less likely to happen.

There were GP leads for long-term illness such as diabetes, asthma and chronic obstructive pulmonary disease COPD. There were also lead nurses who were responsible for running review clinics. This meant that the expertise to manage these chronic conditions was available to patients.

Staffing

Some of the GPs had completed their revalidation and all were appraised annually. Currently none of the other staff had completed their annual appraisals. These should have been completed in March 2014. We were told that the practice was considering how to make the appraisal process of more value to staff and this was why the process had been delayed. However we did not see any evidence that a new system was being developed. Staff we spoke to about their past appraisals said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to frankly examine their performance.

There was an overall training plan. We saw that mandatory training such as fire safety, manual handling and safeguarding had been completed for all staff. This meant that the areas of training that were considered to be most important for the safety of patients and staff had been completed. There was a web-based learning site that offered various courses including compliance with regulation and leadership. Staff had protected learning time. This meant that they could undertake training as group allowing them to share learning experiences. Staff we spoke with said that they were supported to undertake relevant learning. We were given examples that included clinical matters such as diabetes and wound care, as well as non-clinical matters such as management training. This meant that patients were cared for by staff with the clinical expertise and the practice was supported by staff with the necessary administrative skills.

Working with other services

The local Health and Social care co-ordinator attended the two the main surgeries for one session each week. This means that patients who need coordinated support, such as those recently discharged from hospital, could access it more easily. A recent clinical audit had been carried out by working in cooperation with the local hospital. The practice was also working with the local hospital in identifying patients who frequently attended at the accident and emergency department and on finding ways to prevent this. This meant that the practice was proactively engaged with other health and social care providers and other bodies to coordinate care and meet patients' needs, particularly those with complex needs.

There had been an increase in the number of multi-disciplinary team (MDT) meetings. These involved various professionals from outside and inside the practice, for example, district nurses, social services, GPs and other specialists. These meetings involved a careful consideration of a patient's conditions, which included spiritual, where appropriate, as well physical matters. We saw that specialists, such as dieticians, physiotherapists and social workers were tasked at the meetings with meeting the specific needs that had been identified. For example, we saw that social services addressed the specific needs a patient whose home had been flooded.

Working with other practices in the area (federated practices) was in a very early stage. Arrangements had just been put in place with two local practices to carry out peer review of outpatient referrals. This would allow individual GPs to compare the conditions under which they refer with the conditions under which colleagues in surrounding practices refer. It would also allow comparison between referral rates across practices. This meant that there was work across practices to improve the quality, timeliness and need for outpatient referrals.

Health Promotion & Prevention

We were told that all new patients were offered a health check. They were given a questionnaire and offered an appointment with the healthcare assistant. This allowed new patients to be assessed and receive professional advice about their current health and lifestyle options.

There was a range of leaflets available to inform patients about health care issues. These included smoking cessation, diet and healthy living. The practice website had a number of useful links and it was easy to navigate. There

Are services effective?

(for example, treatment is effective)

was a page on long term conditions including mental health, cancer and asthma. There was a page on family health and this included links to "planning your pregnancy", child health and other family matters. This meant that patients were encouraged to take an interest in their health and had the means to take action to improve and maintain it.

The practice had specifically looked at how it could help carers. The issue had been discussed at the patient participation group (PPG) meetings. A member of the PPG had volunteered to be a champion for carers. This meant that on the notice board in the waiting room there were the contact details of someone that carers could contact for help, support and advice. A charity, Carers First, had had a workshop, once a month in the surgery where experts were available to provide further support and guidance to carers.

We spoke with some of the nurses who conducted the various clinics. They told us how they would explain the benefits of particular lifestyles to patients with long term conditions such as diabetes. This meant that patients had the knowledge to live as healthy a lifestyle as their long term conditions permitted.

Are services caring?

Summary of findings

Overall the service was caring. All of the patients we spoke with or who provided feedback were complimentary about the care. We saw and heard that staff were caring, compassionate and empathetic.

Patients said that they had enough information and time with the GP or nurse to meet their needs and that treatment was explained to them.

Our findings

Respect, Dignity, Compassion & Empathy

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. The reception area was a short distance from the waiting room and this meant that patients booking in could not be overheard by those who were already waiting. We listened to the receptionists talking to patients both on the telephone and at the reception. They were consistently kindly and empathetic. We heard one patient being re-assured about a home visit. The patient was told the visit would be after 11.30am and the staff member checked with the patient that it was safe for the matter to wait until then.

Most GPs collected their patients from the reception and it was clear from our observations that generally GPs and patients knew each other by sight. This meant that usually the patient's name was not called out in reception. We saw GPs helping people who had mobility problems, for example, one patient with a walking frame. There was a side window for people to collect prescriptions from the pharmacy. This meant that patients in the main waiting room could not easily overhear when staff checked their identity, usually verbally, before handing over the medicines.

We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. All the consulting rooms had substantial doors and it was not possible to overhear what was being said in them. The rooms were fitted with window blinds and consulting couch curtains and patients said that the GPs and nurses closed them when this was necessary. However, in one room we saw that there was no curtain that could be pulled around the couch. There were different heights of consulting couches so that patients with differing conditions could access them if necessary.

One GP was the lead for end of life care. He was involved in this aspect together with the hospice team when the patient was cared for at home. In addition, the practice held three monthly palliative care meetings when these patients and their care was discussed with others such as the hospice, district nursing services and social services where appropriate. This meant that those patients, whose needs were often complex received care that was coordinated across different disciplines. We saw from the

Are services caring?

NHS choices website that one person had praised the practice for its care and attention when their father had died, describing the GPs as professional, empathetic, informative, and extremely considerate. The administrative staff were also praised for their help at a difficult time.

Involvement in decisions and consent

Patients expressed their views and were involved in making decisions about their care and treatment. Patients who used the service were given appropriate information and support regarding their care or treatment. There was a range of leaflets available in the reception area. These provided health promotion and other medical and health information for patients. In addition to general information, patients were provided with information specific to the condition. When a patient received a diagnosis this was entered onto a computer system which printed information relevant to that diagnosis. This was then given to the patient. We saw from the NHS choices website that one patient had commented on this aspect in particular and felt that the GPs had promoted their independence and autonomy. GPs we spoke with said that when discussing clinical care with patient the options were always explored.

The practice website provided details of access to information in languages other than English that were routinely available. There was no immediate access to translation services, such as language line. However, the practice said this had not been a problem but were aware of these services and would use them if it was necessary. There was information about appointments, clinics and other services on the website. The practice website also provided links to other useful sources of information including various cancers, mental health, AIDS, epilepsy and other health promotion advice. This meant that the practice was actively ensuring that there was access to information to assist patients in making decisions about their care.

Minor operations were carried out at the Trenchwood surgery. We visited the surgery. We saw that there was a separate protocol and consent form for minor operations. Patients were given a consent form and an information leaflet relating to their procedure. Following the procedure they were also provided with a leaflet explaining possible complications and instruction for follow-up. This meant that in the event of complications the patient had a source of information that might help them to decide on an informed course of action. It also meant that patients and relatives were able to contact the practice if necessary and speak to someone about their care.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive. There was an active and effective patient participation group. There was a clear complaints policy. Comments and complaints were acted upon to improve the service.

Patients were concerned about the difficulty getting through on the telephone in the morning.

Our findings

Responding to and meeting people's needs

There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. We heard reception staff offering patients the choice about being seen by a male or female member of staff. We saw that staff were caring. Staff helped patients who had mobility problems and we saw some GPs collecting their patients from the waiting room and chatting with them as they went to the consulting rooms.

The practice actively worked to identify patients who were acting as carers for other people, whether they were registered with the practice or not. A registered charity had arranged a drop-in service once a month at the practice. The charity had allocated money for patients at the practice to be helped in areas such as respite care or equipment.

The practice was developing 'named doctors for all patients over 75 years of age'. These were allocated by identifying their usual GP but this work was, as yet, incomplete.

We looked the process of patient referrals. Generally the GP dictated letters which were subsequently typed by the secretaries. The practice used "choose and book" (the national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment). This process was administered by a secretary. Most patients preferred to be seen locally. There was also a locally administered database (DORIS) that included names and addresses of local specialists, referral proforma and informative leaflets for use during consultations. This meant that staff could accurately and quickly make referrals and ensure that patients' needs were dealt with efficiently.

Access to the service

Patients we spoke with found it difficult to get through on the telephone to book appointments, particularly in the mornings. They found the telephone was often engaged and this was a consistent theme in patients' comments. However they also said that the service, once accessed was good or very good, stating that they always managed to get an appointment on the day they needed it. We also heard from patients that they were seen on time or after only a few minutes wait.

Are services responsive to people's needs?

(for example, to feedback?)

In the 2013 GP patient survey the result for the practice in this area was among the worst, with the percentage of patients rating their ability to get through on the phone as 'very easy' or 'easy' at only 57.1%. However, the percentage of patients rating their experience of making an appointment as 'good' or 'very good' was 74.8% - in the middle range.

The appointment system was used flexibly. Fifty percent of appointments were available on the day with the remainder available for pre-booking up to six weeks in advance. There were duty GPs available morning and evenings. All of their appointments were available on the day. This helped to ensure that patients could be seen at short notice or on the day they telephoned.

The practice had recently installed an online booking service. Patients we spoke with said that this allowed for greater flexibility. We saw the system in use. When patients booked online this was displayed on the receptionists' screen and showed them that the "slot" was taken. They were therefore better able to manage the other demands on reception. We were told this new system should relieve some of the pressure on the telephone system but as yet there was no evidence to this effect.

We saw a practice brochure that provided information on the services provided by the practice. This included surgery times, useful telephone numbers and general medical advice. The practice had an informative website on which there were details of staff, clinics and other supporting services. There was clear direction on how to access the out of hours service. The practice had extended hours surgeries on Saturday mornings and Monday evenings to meet patients' needs such as commuters. This demonstrated that they were responsive to the needs of the patients in their community.

We talked to the lead GP about services for the homeless. He said that the practice did treat homeless patients and travellers, though it was rare that they presented at the practice. They registered as temporary patients. The usual pattern was that they would be seen frequently for a short period for a particular aliment then they stopped attending.

Concerns & Complaints

There was an active patient participation group (PPG) and we spoke to some members of the group. They said that there was a high degree of satisfaction with the standards in the practice. Patients liked a practice where GPs and patients knew each other.

We looked at the minutes of meetings of the PPG. We saw that the practice responded to patients' views. For example the PPG had invited a pupil from a local school to a meeting to give them an insight into how young people perceived the practice. As a result the group had asked the practice to make several changes to the practice website so it would be of more use to young people. We saw that the practice had made these changes which demonstrated they were responsive to patients' needs.

There was a complaints policy in place. It included timescales by which a complainant could expect to receive a reply. Four members of staff had undertaken specific complaints training. In the year to end March 2014 there had been nine complaints. We saw that these had been fully and appropriately investigated. Where appropriate, the practice had apologised and/or explained how the incidents had come about. There was learning from complaints (and comments) which were discussed at the weekly practice meetings and changes were made to improve services. This showed that the practice responded appropriately to patients' complaints.

Are services well-led?

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

Summary of findings

Overall the service was well led. There was a strong structure and staff were clear about their accountabilities. There was an open and supportive culture.

There were audits and risk management tools in place in place to ensure the safety of patients, staff and visitors. There was strong clinical governance, which ensured that lessons were learned at the appropriate levels within the organisation. The practice recognised strategic risks and had plans in place to mitigate them.

Our findings

Leadership & Culture

All the staff we spoke with described an organisation that was open and transparent. One staff member said that they had worked in three practices and this was the best. When asked why, they said that it was because the GPs were very approachable, all (clinical) staff were involved in the clinical meetings and they all felt part of one team. This view was supported by other clinical and administrative staff with whom we spoke. This meant that staff could question decisions made by others and improve the quality of the care that patients received.

There was regular discussion among the partners about the strategic direction of the practice and once a year the partners went away for a weekend where the strategic issues could be discussed without interruption from the everyday business of the practice. These issues included how demographic changes or changes to staffs' personal lives might impact on need to recruit staff. There were financial considerations, for example a new wing had recently been built at one of the surgeries and this had been a strategic consideration for the partners.

Governance Arrangements

There were a range of mechanisms to manage governance of the practice. Primarily this revolved around the clinical and non-clinical meetings attended by people both within and external to the practice. There was a weekly meeting of the GPs where clinical issues were discussed as well as resolving immediate matters such as covering for unexpected absences. This meant that the immediate needs of patients were always being addressed.

There were other meetings specific to various functions. For example, there was a clinical meeting and a practice meeting each month and a GP trainer's group meeting and palliative care meetings every other month. There were full staff meetings and meetings of the Patient Participation Group three times a year. We saw that the system of meetings was effective because staff talked about the impact it had on their practice. They gave an example of a change to prescribing practice being discussed at one meeting. We looked at the minutes of some of the meetings (with confidential information removed) and saw that the discussions had a direct impact on patient care. For example, one patient had been forced from their home by

Are services well-led?

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

recent flooding. This was the subject of a multi-disciplinary team meeting involving clinicians and social workers so that the patient could be supported until their home was ready for them to move back in.

Governance arrangements were supported by certain staff leading in certain areas. There were GP leads for long-term illness such as diabetes, asthma and Chronic obstructive pulmonary disease (COPD). Both these areas also had lead nurses who were responsible for running review clinics.

Systems to monitor and improve quality & improvement

The practice was a training practice and all the clinical staff were to some degree involved in the training of future GPs. This meant that the quality of GP registrar (trainee) decisions was under near constant review by their trainers. The trainer GPs within the practice met every other month. In addition the practice was subject to scrutiny by the Health Education Kent, Surrey and Sussex (called the Deanery). Trainee GPs were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. This meant that GPs' communication and clinical skills were regularly under review.

The quality of care was reflected in the practice achievements against the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The practice recognised where there had been a loss of quality in QOF and during clinical meetings specific GPs undertook to address the issues and improve their results. This was apparent in some of the QOF outcomes such as Asthma and Chronic Obstructive Pulmonary Disease, which showed that there had been marked improvements in some of the indicators reflecting the quality of care provided to patients following the work of the named leads. This demonstrated that the practice responded to the information available and actively sought to make improvements in the quality of care for their patients.

Patient Experience & Involvement

The practice actively worked to identify patients who were acting as carers for other people, whether those people were registered with the practice or not. A registered charity had arranged a drop-in service once a month at the practice. The charity had allocated money for patients at the practice to help them in areas such as respite care or equipment. The practice was willing to vaccinate the carers of patients in appropriate cases, so that their health was protected.

We looked at the minutes of meetings of the PPG. We saw that the practice was responding to patients' views. For example various members of the PPG had agreed to act as champions for different patient groups. There was a PPG member for mothers and babies, disabled patients, older people, medical matters, family matters and patients with chronic conditions. There was a patient survey. The results were published on the practice's website, and highligted three main concerns: booking of appointments, methods of reducing the number of patients who missed appointments and improving disabled access to the Trenchwood surgery. There was a plan in place to address the issues.

Staff engagement & Involvement

Staff we spoke with felt that the practice was open to suggestions from staff. They said that they were made aware of comments and complaints through meetings and emails. They knew that the partners discussed comments and complaints and took action to address any issues.

Learning & Improvement

Staff were aware of the incident reporting policy and we saw books at both receptions (Westwood and Trenchwood surgeries) where staff could, and did, make reports. The practice manager or deputy practice manager reviewed the significant events policy every six months. This ensured the policy was kept up to date with any changes to the NHS governing documents that defined significant events. This meant that patients were better protected against the risks involved when new practices or equipment were brought into use.

We looked at some reported events and saw that they had generated an action plan, usually over a three-month period, to reduce the risk of the event happening again. We saw examples of completed action plans. There was a full staff meeting three times a year, which allowed staff to express their views about the practice and ensured that everyone was updated on important changes. The partners made a particular effort to hold social events where the staff could attend. They felt this reduced barriers between

Are services well-led?

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

staff and helped to engender a spirit of trust and confidence so that staff felt they could raise issues of concern safely. Staff also felt that the social interactions made senior staff more approachable.

Identification & Management of Risk

The partners met once a year for a strategic discussion on the future of the practice. This included consideration of any changes to population groups or increases in numbers, such as those posed by any housing developments in the area. The partners considered the strategic risks. They discussed and shared them where appropriate. For example, nobody from the area sat on the Clinical Commissioning Group (CCG), they stated that the links were tenuous and the practice might not be aware of wider plans for the locality. This meant that the practice sometimes felt isolated and the relationships needed to be strengthened and improved. This had been openly discussed with the patient participation group. It was recorded in the minutes and published. This had been brought to the attention of the CCG and some measures had been put in place to improve the situation by grouping practices together under a member of the CCG board.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Older people represented a large part of the general practice population. Older people were cared for as part of the practice's patient centred approach, which focused on individuals' needs and preferences.

Our findings

Safe

The practice provided annual flu vaccination clinics for older people, to provide protection and prevention from contracting the virus and associated illness. We found that the practice had systems in place to manage medicines safely and help protect older patients from the risks associated with medicines. We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for older patients.

Effective

The practice was developing 'named doctors for all patients over 75 years of age'. These were allocated by identifying their usual GP but this work was, as yet, incomplete.

There was a wide choice of health promotion material both on paper and web-based. A section of the material was called "seniors" and related to the care and health of older people. Various members of the PPG had agreed to act as champions for different patient groups. There was a PPG member older people.

Caring

One GP was the lead for end of life care most of these patients were older people. He was involved in this aspect together with the hospice team when the patient was cared for at home. In addition, the practice held three monthly palliative care meetings with other agencies. This meant that those patients, whose needs were often complex received care that was coordinated across different disciplines.

Many of the patients that we spoke to were older people. Without exception they felt that the GPs were caring and treated them with dignity and respect.

Responsive

Various members of the PPG had agreed to act as champions for different patient groups. There was a PPG member for older people.

Older people

Well led

We saw evidence that the practice undertook clinical audits to improve outcomes for older patients. The results were reviewed against national data to determine any changes that could be made to care/treatment pathways and clinical therapies to improve outcomes for older patients. The partners reviewed strategic factors impacting on the practice These issues included how demographic changes, in particular the increasing number of older patients, might impact on the need to recruit staff with particular skills.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

People with long term conditions were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. There were specialist clinics and GPs with specialities to address the needs of people with long term conditions.

Our findings

Safe

The practice provided annual flu vaccination clinics for patients with long term conditions, to provide protection and prevention from contracting the virus and associated illness.We found that the practice had systems in place to manage medicines safely and help protect patients with long term conditions from the risks associated with medicines. We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients with long term conditions.

Effective

There was a wide choice of health promotion material both on paper and web based. A section of the material was called "Long term conditions" and related to the care and health of people with long term conditions such as diabetes, heart disease and cancer. There were clinics for chronic disease such as asthma, coronary heart disease and diabetes. As well as GPs and nurses employed at the practice, there were other team members attached to the practice. These included hospice nurses who met the needs of patients with life-limiting conditions. There were GP leads for long-term illness such as diabetes, asthma and chronic obstructive pulmonary disease COPD. The practice had undertaken an audit of diabetic care, which had resulted in more assessments of patients with diabetes being conducted more accurately.

Caring

Patients told us that their wellbeing was monitored and they were re-called for routine checks and follow-up appointments on a regular basis. They also told us that they were treated with dignity and care by their GPs. They particularly praised the nursing staff for their care and kindness.

People with long term conditions

Responsive

There was an active Patient Participation Group. Various members of the PPG had agreed to act as champions for different patient groups – including patients with chronic conditions. There were clinics for chronic disease such as asthma, coronary heart disease and diabetes. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included hospice nurses who met the needs of patients with life limiting conditions.

Well led

We saw evidence that the practice undertook clinical audits to improve outcomes for patients with long term conditions. The results were reviewed against national data to determine any changes that could be made to the care or treatment pathways and clinical therapies to improve outcomes for patients with long term conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Mothers, babies, children and young patients were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. There were midwifery clinics and a school nurse service.

Our findings

Safe

The practice provided annual flu vaccination clinics for mothers, babies, children and young patients, to provide protection and prevention from contracting the virus and associated illness. We found that the practice had systems in place to manage medicines safely and help protect mothers, babies, children and young patients from the risks associated with medicines. We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for mothers, babies, children and young patients. There were GP partner leads for both adult and child safeguarding. All staff had had up-to-date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral.

Effective

There was a wide choice of health promotion material both on paper and web based. A section of the material was called the pregnancy care planner and gave advice under the headings "Before you are pregnant", "Your pregnancy and labour" and "You and your baby". There was a further section under family health related to the health of children and young people. There were child health and midwifery clinics. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included school nurses who met the needs of children and young people.

Caring

We spoke with one mother who told us she was very pleased with the care and service that she had received. She felt the staff providing the service empathised and understood some of the difficulties that she faced. There was a member of the PPG who championed and encourage breastfeeding by new mothers.

Responsive

There was an active Patients' Participation Group. Various members of the PPG had agreed to act as champions for

Mothers, babies, children and young people

different patient groups. There was a PPG member for patients who were mothers and babies. The PPG had invited a pupil from a local school to a meeting to give them an insight into how young people perceived the practice. As a result the practice had changed some aspects of its web site to make it more accessible to young people. There were child health and midwifery clinics. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included school nurses servicing the needs of children and young people.

Well Led

We saw evidence that the practice undertook clinical audits to improve outcomes for mothers, babies, children and young patients .The results were reviewed against national data to determine any changes that could be made to the care or treatment pathways and clinical therapies to improve outcomes for them.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Working age patients were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences.

Our findings

Safe

The practice provided annual flu vaccination clinics for working age patients, to provide protection and prevention from contracting the virus and associated illness. We found that the practice had systems in place to manage medicines safely and help protect working age patients from the risks associated with medicines. We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for working age patients.

Effective

There was a range of clinics and services such as a diabetes, blood pressure and general check-ups to service the needs of the working age patients. There was advice on healthy living.

Caring

There were a number of leaflets in the waiting area aimed at the working age patient such as those on healthy life style exercise and weight control.

Responsive

The practice had extended hours surgeries on Saturday mornings and Monday evenings to meet the needs of patients such as commuters.

Well Led

We saw evidence that the practice undertook clinical audits to improve outcomes for working age patient. The results were reviewed against national data to determine any changes that could be made to the care or treatment pathways and clinical therapies to improve outcomes for them.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Patients in vulnerable circumstances were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences.

Our findings

Safe

The practice provided annual flu vaccination clinics for patients in vulnerable circumstances, to provide protection and prevention from contracting the virus and associated illness. We found that the practice had systems in place to manage medicines safely and help protect patients in vulnerable circumstances from the risks associated with medicines. We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients in vulnerable circumstances. There were GP partner leads for both adult and child safeguarding. All staff had had up to date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral.

Effective

The practice provided routine care to patients in vulnerable circumstances who may have poor access to primary care. The practice served homeless and travelling patients as the need arose. There were translation services available and practice website listed languages that were routinely provided.

Caring

The premises were approached by a ramp which provided easy access for patients with reduced mobility. We saw staff helping patients with reduced mobility. There were duty GPs available morning and evenings. All of their appointments were available on the day. This helped to ensure that vulnerable patients could register with the practice and be seen on the day if necessary.

People in vulnerable circumstances who may have poor access to primary care

Responsive

Some vulnerable patients might find it difficult to attend the practice for care and treatment. We was evidence that GPs or the district nurse would support and treat patients at home if that was necessary.

Well Led

The practice had few vulnerable groups that had been identified as residing in the area. But was open to responding to them if required.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Patients experiencing poor mental health were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences.

Our findings

Safe

We found that the practice had systems in place to manage medicines safely and help protect patients experiencing poor mental health from the risks associated with medicines. We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for patients experiencing poor mental health. There were GP partner leads for both adult and child safeguarding. All staff had had up to date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral.

Effective

There was a wide choice of health promotion material both on paper and web based. A section of the material was about mental health and related to the care and health of people with mental health problems. There were a number of links to other organisations such as the Alzheimer's Society, the Mental Health Foundation and Healthtalkonline, a charity website. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included counsellors who met the needs of patients with mental health problems. The practice consistently scored highly in the QOF results relating to the care of patients experiencing poor mental health, achieving between 4% and 10% better than comparable practices.

Caring

There was routine care offered to patients experiencing poor mental health. The practice tried to ensure that they were seen by the same GP. There were double appointments available if necessary for those with mental health problems who needed more time to talk to their GP.

Responsive

As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included counsellors who met the needs of patients with mental health problems.

People experiencing poor mental health

Well Led

The superior performance in mental health acre evidenced by the improved QOF scores was achieved against an average if not mediocre performance against the same set of indicators the previous year.