

Highcliffe Medical Practice

Quality Report

Higham Surgery
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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?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Highcliffe Medical Practice on 5 November 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient participation group (PPG), interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice was rated as good. This is because we found the practice to be good for providing well-led, effective, caring, responsive and safe services. It was also good for providing services for all patient population groups.

Our key findings were as follows:

- The practice was clean and patients told us that they had no concerns with the cleanliness of the practice

- Patients were happy with the care treatment and support they had received. Patients told us they had been involved and felt included in decisions about their care, treatment and support at the practice.
- Patients were happy with the current appointment system and said it was easy to obtain an appointment when they needed one and they were able to get through on the telephone.
- The practice engaged patients and staff sufficiently in the operation of the service or ensured that staff had received appropriate learning and development opportunities to enable them to provide effective care, treatment and support to patients.

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?

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

Good



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Clinical Excellence (NICE) guidance was referenced and used routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. The practice carried out appraisals and there were personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Patients were treated with kindness as well as respect and confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified as being required. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their individual needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Good



Summary of findings

Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision statement and a strategy to deliver this. All staff were aware of the practice vision statement and their role in supporting its achievement. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures that governed activity and regular governance meeting had taken place. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had not received appropriate inductions, but had received regular performance reviews and attended staff meetings and events

Good



Summary of findings

What people who use the service say

We spoke with twelve patients on the day of our inspection who were all very positive about the services they had received at Highcliffe Medical Practice. They told us the staff were always caring, supportive and sensitive to their needs, and they felt safe when visiting the practice or when the GPs visited them in their homes.

Patients indicated they had no concerns with regard to hygiene and the cleanliness of the practice. They told us staff always washed their hands before and after examining them or carrying out a procedure.

We heard how patients felt that they were involved in their care and treatment and that options were always explained and discussed with them. They told us that staff always gave them enough information to be able to make decisions with regard to their care and that they could make these decisions in their own time.

Patients said they were treated with dignity and respect when using the practice and that they could request to speak to one of the reception staff privately if they wished.

Patients we spoke with told us they could always get an appointment when they needed one and with the GP of their choice. They said the online booking system allowed them to look at appointment availability and choose the time, day and which GP they preferred to see.

We also received positive comments from patients who had completed comment cards prior to our inspection. All six comment cards indicated that patients were more than satisfied with the support, care and treatment they had received from the practice.

Highcliffe Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**. The team included a GP specialist advisor, an expert by experience and a practice manager specialist advisor.

Background to Highcliffe Medical Practice

Highcliffe Medical Centre and Cliffe Surgery provide primary medical services Monday to Friday from 8am to 6pm each week and operates extended opening hours from 7am on a Thursday and until 8pm on Tuesday evenings. The practice is situated in Higham Kent with a branch surgery in Cliffe and provides a service to approximately 5,300 patients in the locality across the two practices.

Routine health care and clinical services are offered at the practice, led and provided by the nursing team. There are a range of patient population groups that use the practice which holds a general medical services (GMS) contract with the Medway area clinical commissioning group (CCG). The practice does not provide out of hours services and information is available to patients about how to contact the local out of hour's services provider.

The practice has three male and one female GP partners as well as one male and two female registrar GPs. There are two female practice nurses and two health care assistants, both female. The practice has a number of administration / reception and secretarial staff as well as a practice manager.

The practice has more patients in the working age group than the local and national average and a higher number of older patients over the age of 65. The number of patients recognised as suffering deprivation is lower than the local and national average. The practice supports a significantly higher number of patients who have a caring responsibility than the national average.

Services are delivered from:

Highcliffe Medical Practice

Higham Surgery

Hermitage Road,

Higham

Rochester

Kent

ME3 7DB

And:

Cliffe Surgery

Millcroft Road

Cliffe

Rochester,

Kent

ME3 7QN

Why we carried out this inspection

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

Detailed findings

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 was 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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew, including the NHS area team, the locality clinical commissioning group (CCG) and the local Healthwatch.

We carried out an announced visit on the 5 November 2014. During our visit we spoke with a range of staff including GPs, nursing staff, receptionists and

administration staff. We spoke with patients who used the service. We placed comment cards in the surgery reception so that patients could share their views and experiences of the service before and during the inspection visit.

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)

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient noticed that a vaccine they had attended for was out of date. The vaccine had not been administered. The practice had reflected on the incident, discussed it at one of the weekly meetings, and had taken action to reduce the risk of this happening again.

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

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years. Significant events were a regular practice meeting agenda item and a dedicated meeting occurred twice monthly to review actions from past significant events and complaints. These were also discussed at a weekly meeting each Monday. There was evidence that learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Incident forms were available on the practice intranet. Once completed these were sent to the practice manager who used the system to monitor and manage incidents. We tracked four incidents records were completed in a comprehensive and timely manner and there was evidence of action taken as a result. For example, an inappropriate medicine regime had been prescribed. Staff responsible had been sent on a course for further training. A presentation was given at a staff meeting so that all

relevant staff were aware of the correct prescribing regime and selection criteria. An audit was completed with regard to this particular prescribing regime and there were plans to re-audit in the new year.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at the weekly and fortnightly clinical and general meetings to ensure all staff were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. 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. We looked at records where abuse has been suspected. Staff were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children who had been trained at level three 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 system to alert staff to vulnerable patients on the practice's electronic records. This included information that alerted staff to any relevant issues when patients attended appointments. For example children subject to child protection plans were immediately highlighted by a prompt as their electronic records were accessed by staff. 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 GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services.

Are services safe?

The practice had a chaperone policy which was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

We checked medicines stored in the dispensary, 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 medicines were kept at the required temperatures. This was followed by the practice staff, and the action to take in the event of a potential failure was described. However we found that each refrigerator did not have a backup battery powered thermometer so if there was a power cut the temperature of stored medicines could be monitored.

The practice had a system to check that 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.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. 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 protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who

generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were appropriate and necessary.

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.

The practice held stocks of controlled drugs in the dispensary (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. We observed this process was working in practice.

We saw that during the day when the dispensary was in use the access door was left open. Patients had to walk past the open door to get to consultation rooms. Staff told us that a stable door had been requested so that security would be improved. Staff assured us that the dispensary was never left unattended and that the open door was always supervised. Patients we spoke with said that there was always someone in the dispensary to help them when it was open.

Are services safe?

We noted that labels on medicines dispensed did not have all of the information legally required, such as the address of the practice.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and cleaning records were kept. 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 control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead for infection control had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. Staff told us how they would use PPE when changing a dressing and how to dispose of the used PPE correctly and safely. There was also a policy for needle stick injury,

Hand hygiene techniques signage was 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 had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was

carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. The most recent check had identified a lowest possible risk rating for legionella.

Equipment

Staff we spoke with told us they had sufficient 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, equipment for measuring breathing and a machine for measuring blood clotting status.

Staffing & 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 via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting GPs, nurses and administration 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 for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included forecasting spread sheets, annual and monthly checks of the building, the practice

Are services safe?

environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, 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 to manage emergencies. We saw records that demonstrated all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Staff followed a system to regularly check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. Records demonstrated that staff were up to date with fire training and regular fire drills were undertaken by the practice.

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 treatment approaches. They were familiar with current best practice guidance accessing 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, implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. Staff told us they completed thorough assessments of patients' needs in line with NICE guidance which were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease as well as asthma and that 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. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

The senior GP partner showed us data from the local clinical commissioning group (CCG), of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were on appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed within 1 week by their GP.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with followed national standards for the referral of suspected cancers to be referred and all had been seen within two weeks of

consultation. We saw minutes from meetings where regular review of elective and urgent referrals were made, and that planned improvements to practise were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us eight clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit, such as clear guidelines and training received for a selection and medicine regime criteria. Other examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

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 national performance measurement tool. For example we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information they collected for the QOF and their performance and compared them to national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an annual medication review, and the practice met all the

Are services effective?

(for example, treatment is effective)

minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and coronary heart disease. This practice was not an outlier for any QOF (or other national) clinical targets.

The 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 upon 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, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

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 the latest prescribing guidance was being used. The information technology (IT) system flagged relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of 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 oversight and a good understanding of best treatment for each patient.

The practice also 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 comparable to other services in the area. GPs attend monthly meetings with a programme board to discuss performance and create working groups of local surgeries to provide quality care to patients in each group area.

Effective staffing

Practice staff 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. A good skill mix was noted amongst the doctors with two having additional diplomas in minor surgery, and two with diplomas in geriatric health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation.

(Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example, a course relating to conflict resolution had been arranged following a significant event where a patient had become violent. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). We

Are services effective?

(for example, treatment is effective)

saw that the policy for actioning hospital communications was working well in this respect. The practice undertook an audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients e.g. 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.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. We looked at a number of referrals to different clinics including urgent referrals. Staff demonstrated how this process was followed up and audited, to ensure that referrals were not missed and the information had been received by the clinic or department it had been sent to. Staff reported that this system was easy to use.

An electronic patient record "Vision online" was used by all staff to coordinate, document and manage patients' care. All staff were fully trained in the use of 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 in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 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. For some specific scenarios where capacity was an issue, the practice had a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with learning disabilities 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. The practice kept records and showed us all of their care plans had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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. We were shown an audit that confirmed the consent process for minor surgery had been followed in 100% of cases.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst 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 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that a high percentage of patients in this age group took up the offer of the health check. A GP showed us how patients who had risk factors for disease identified at the health check were followed-up within two weeks and were scheduled for further investigations.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in

Are services effective? (for example, treatment is effective)

offering additional help. For example, the practice kept a register of all patients with learning disabilities and all were offered an annual physical health check. Practice records showed 100% had received a check up in the last 12 months. The practice had also identified the smoking status of 60% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 78% which was better than others in the CCG. 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 annually.

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 immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice's Patient Participation Group. The evidence from 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 national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them and 86% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received five completed cards and the all 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. We also spoke with eleven 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice telephone system was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing

potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. Records confirmed this and demonstrated that learning from such incidents had taken place.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations although these were very rare at the practice.

Care planning and involvement in decisions about care and treatment

The 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 patient survey showed 83% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area and nationally. The results from the practice's own satisfaction survey showed that 90% of patients said they were sufficiently involved in making decisions about their care.

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 patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients in general are aware of the variety of appointments available and are satisfied with the provision of appointments and the appointment making process... The patients we spoke to on the day of our inspection and the

Are services caring?

comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and the website also signposted patients and people close to them to 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 that they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were called by their GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. Patients we spoke to who had had a bereavement confirmed told us they had received this type of support and said they had found it helpful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. GPs at the practice are involved in local working groups that meet monthly to discuss and develop health services in the area to meet the needs of their patients.

Continuity of patient care and accessibility to appointments with a GP of choice was maintained by the practice when staff changes had taken place. Longer appointments and appointments with a named GP or nurse were available for patients who needed them including those with long term conditions.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). Patients had requested a photo board in the waiting area of all the staff and their roles. We saw that this had been actioned and also showed which of the nursing staff were responsible for each particular clinic and when these were held.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs. The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. We saw how the wishes of terminally ill patients were shared with the local out of hour's provider and the local hospitals.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. The premises were seen to be accessible for disabled patients, having level access and disabled parking spaces close to the entrance door. A toilet which is accessible to people with limited mobility was available and there were also baby changing facilities for mothers with babies to use. We saw that the reception desk did not have a lowered area to accommodate patients using wheelchairs. We observed staff coming out to greet patients who had limited mobility and helped them throughout their visit.

The practice had access to a telephone translation service but had not had the need to use it to date.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team meetings.

Access to the service

Appointments were available at the Higham practice from 8am to 6pm on Monday, Tuesday, Wednesday and Fridays and 07:00am to 1pm on a Thursday. The branch surgery at Cliffe is opened during core hours as Higham but were open until 8pm on a Tuesday and were closed Wednesday afternoons. Each clinical session offered a number of different appointment types, such as book on the day, pre-bookable, urgent and telephone consultations.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. They confirmed they were able to see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice.

Comments received from patients showed that patients in urgent need of treatment had been able to make

Are services responsive to people's needs?

(for example, to feedback?)

appointments on the same day of contacting the practice. One patient we spoke with told us how they needed an urgent appointment for one of their family and it was arranged immediately.

The practice's extended opening hours, later on a Tuesday and early on a Thursday was particularly useful to patients with work commitments. This was confirmed by patient comments who stated that they preferred and used these extended hours.

The practice was situated on the first and second floors of the building with one service for patients on the first floor, although this could be carried out downstairs should patients have problems with mobility. The practice had room in the corridors of the practice for the use of patients with wheelchairs. This made movement around the practice easier and helped to maintain patients' independence.

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 a predominant population of English speaking patients though it was able to cater for other different languages through translation services and on the practice website.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints system, we saw posters displayed in the waiting area and there was information on how to make comments or a complaint on the practice website. This included reference to the Health Service Ombudsman. The Health Service Ombudsman is a free service set up by parliament for individuals and the public to investigate complaints about healthcare. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at fourteen complaints received formally by letter and informally in person in the last twelve months and found these had been satisfactorily handled and dealt with in line with the complaints policy timeframes. The correspondence we looked at included progress reports to patients as the complaint investigation progressed so that they were continually updated. All of the complaints we looked at had been resolved and we saw where further training had been identified, such as customer service training.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and one theme had been identified. We saw that training in customer service had been carried out for reception staff. Other lessons learnt from individual complaints had been acted upon.

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 statement to deliver high quality care and promote good outcomes for patients. We found details of the vision statement and practice values were part of the practice's forward business plan. The practice vision statement and values included the practice to offer a friendly, caring good quality service that was accessible to all patients. To create and maintain a good working environment for staff to develop and flourish.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at fifteen of these policies and procedures and staff had completed a cover sheet to confirm they had read the policy and when. All fifteen policies and procedures we looked at had been reviewed annually and were up to date.

The practice held fortnightly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. 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 completed a number of clinical audits, for example, minor surgery where it was identified that two procedures out of fifty seven had wound infections and the GP had changed the way in which would of this type were closed up following surgery. Also other clinical audit had been carried out in areas relating to prescribing, gestational diabetes and patients end of life care wishes.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as continuity of the service in severe weather or staff shortages, fire safety and health and safety

of the premises. We saw that the risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, vaccine storage and what to do in the event of the vaccine fridge failing.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly each month. 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. We also noted that the team held social events periodically throughout the year.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment, disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and 54% of patients had not been aware that telephone consultations were available. We saw as a result of this the practice had raised awareness of telephone consultation appointments by posters and informal conversations with staff. We were shown a report on comments from patients for the period 2013/14 which had indicated that a high number of patients were attending A&E. We saw that the

Are services well-led?

Good 

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

practice was raising awareness with regard to alternative care options such as services available at a local walk in centre, the minor injuries unit and emergency dental services.

The practice had an active patient participation group (PPG). The PPG contained representatives from various population groups; including older people and working age. The PPG had carried out surveys and met annually. 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 are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they 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 whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training

and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training.

The practice was designated as a 'learning practice' where trainee GPs were offered placements to develop their knowledge, skills and clinical competencies. We were told by the GPs that this was considered important to the practice in strengthening and supporting an exchange of learning and innovation amongst all clinicians. GP registrars we spoke with told us that they felt supported and worked in a learning environment. Staff told us they felt part of a cohesive team and that their input was appreciated.

The practice had completed reviews of significant events and other incidents and shared results with staff via meetings to ensure the practice improved outcomes for patients. For example, A near miss occurred when a patient noticed that a vaccine prepared for administration was out of date. An immediate stock check was initiated of all of the vaccines held by the practice and the branch surgery and dispensary. A meeting was called and the incident discussed with the nursing staff. As result stock checking and rotation are checked on a more frequent basis. Vaccines are checked at least twice prior to administration and the date is shown to the patient or carer to verify that it is within an expiry date