Clanricarde Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Clanricarde Medical Centre on 22 September 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Though some staff where not clear to whom and by what route some incidents should be reported. Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The Quality and Outcomes framework results for the practice showed a consistently positive and improving patient outcomes which was against a national trend. Staff had received training appropriate to their roles and some further training needs had been identified and planned.
- The practice's uptake for the cervical screening programme was excellent. It had bettered the national performance each year over the last nine years by between by between 14% and 17%.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice namely:

- The practice had encouraged different providers and clinics to the practice that enabled patients to receive a wide range of holistic care and treatments which were not usually available at a single site
- Data showed that the practice's performance in monitoring and maintaining the health of patients with long-term conditions and those experiencing poor mental health was significantly better than that achieved nationally or locally. Where national and local performance had fallen slightly in the management of these conditions, this practice had maintained or improved its performance.

However there were areas of practice where the provider should make improvements:

- The practice should review arrangements at the reception area to try and improve patient confidentiality
- Review communication to try and improve staff's knowledge of the practice's vision and policies.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses, though some staff where not clear to whom and by what route some incidents should be reported. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or often well above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and local guidance and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and training planned to meet them. There was evidence of appraisals and personal development plans for all appropriate staff. The practice provided a wide range of services and staff worked with other providers in multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and the clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other providers.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Most staff were clear about the vision and their responsibilities in relation to this, some staff were less clear about this. There was a defined leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought and acted upon feedback from staff and patients. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events, though there were no whole practice meetings. The practice led in areas such as GP federation, driving improvements to local services.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Outstanding

The practice is rated as outstanding for providing services to patients with long-term conditions. Data showed that the practice's performance in monitoring and maintaining the health of patients with long-term conditions, in line with current best practice guidelines, was significantly better than that achieved nationally or locally. Where national and local performance had fallen slightly in the management of long-term conditions, such as asthma, diabetes and chronic obstructive pulmonary disease, the practice had maintained or improved its performance. This had been consistent over the period of registration with the Care Quality Commission.

Nursing staff had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority and were followed up when they were discharged from hospital. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were in line with national averages for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

We saw examples of joint working with midwives, health visitors and school nurses, this included midwife led ante-natal clinics. The

Summary of findings

practice's uptake for the cervical screening programme was 95.66%, which was markedly better than the national average of 81.7% and put the practice in the top 2% in the country. The practice's uptake for the cervical screening programme had bettered the national performance each year over the last nine years by between 14% and 17%.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. This included chlamydia testing kits which were available without having to ask at reception.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had recently signed up to provide an enhanced service for patients with learning disability and was planning how to provide out annual health checks for all these patients. It offered longer appointments for people with a learning disability. The practice had a system of registering homeless patients using the details of a local homelessness charity.

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

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health,

Summary of findings

including those with dementia. Ninety three per cent of patients diagnosed with dementia had a care plans and had received a face to face review in the last twelve months, this was 10 percentage points above the local average.

In 2013 and 2014 94% of mental health patients had a care plan, agreed between them, their family and/or carers and their GP. Between 2009 and 2013 100% of patients had had such a care plan.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. There was a monthly psychiatric community nurse clinic and a monthly memory clinic at the practice.

Summary of findings

What people who use the service say

The national GP patient survey results showed the practice was performing better than or in line with local and national averages.

- 74% find it easy to get through to this surgery by phone, this was the same as both the clinical commissioning group (CCG) average and the national average.
- 87% find the receptionists at this surgery helpful, this was the same as both the CCG average and the national average.
- 86% of patients, with a preferred GP, usually get to see or speak to that GP, this is significantly better than a CCG average of 72% and a national average of 60%.
- 95% were able to get an appointment to see or speak to someone the last time they tried, this is significantly better than a CCG average of 88% and a national average of 85%.
- 93% say the last appointment they got was convenient, this was in line with both the CCG and national averages
- 83% describe their experience of making an appointment as good, compared with a CCG average of 78% and a national average of 74%.
- 88% usually wait 15 minutes or less after their appointment time to be seen, this is significantly better than the CCG average of 64% and a national average of 65%.
- 78% feel they don't normally have to wait too long to be seen, this is significantly better than the CCG and national average of 57%.

As part of our inspection we asked patients to complete comment cards provided by the CQC. We received 13 comment cards of which 11were positive about the standard of care received. The two remaining cards contained both positive and negative comments. One comment related to car parking which was outside of the practice's effective control. Themes that ran through the positive comments were; staff, including reception staff, were very caring and were able to provide appointments for patients often at short notice, staff listened to patients and GPs and nurses received praise for their diagnostic and clinical skills.

Areas for improvement

Action the service SHOULD take to improve

- The practice should review arrangements at the reception area to try and improve patient confidentiality
- Review communication to try and improve staff's knowledge of the practice's vision and policies.

Outstanding practice

- The practice had encouraged different providers and clinics to the practice that enabled patients to receive a wide range of holistic care and treatments which were not usually available at a single site
- Data showed that the practice's performance in monitoring and maintaining the health of patients with long-term conditions and those experiencing poor mental health was significantly better than that achieved nationally or locally. Where national and local performance had fallen slightly in the management of these conditions, this practice had maintained or improved its performance.

Clanricarde Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Clanricarde Medical Centre

Clanricarde Medical Centre is a GP practice located in the centre of Tunbridge Wells, Kent and provides care for approximately 10,250 patients. The age of the patients on the practice list is very similar to the national average. There are marginally more patients under 18 years of age than nationally and marginally fewer patients over 65 years of age than nationally. The practice is in an area of comparative wealth with income deprivation scores about half of those nationally.

There are seven GP partners, four female and three male. There are five female practice nurses and a female healthcare assistant. The practice has a general medical services contract with NHS England for delivering primary care services to local communities and also offers enhanced services for example, extended hours and minor surgery. The practice participates in the national programme of post-graduate training for doctors by offering a placement in a GP practice to doctors who have graduated and completed at least one year as a hospital doctor.

The practice is open between 8.30am and 6.30pm Monday to Thursday and 8.30am to 6pm on Friday. Extended hours surgeries are from 7am to 8am Tuesdays and Thursdays and 6.30pm to 7.30pm Wednesdays and Thursdays.

Services are delivered from;

Clanricarde Medical Centre

Abbey Court

7-15 St Johns Road

Tunbridge Wells

Kent,

TN4 9TF

The practice has opted out of providing out-of-hours services to their own patients. Care is provided by Integrated Care 24 (IC24). There is information available to patients on how to access out of hours care.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data,

Detailed findings

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.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 22 September 2015. During our visit we spoke with a range of staff including GP partners, receptionists and administrators. We spoke with patients who used the service.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia).

Good

Are services safe?

Our findings

Safe track record and learning

There were systems for reporting and recording significant events. Staff told us they would inform the practice manager of any significant events. Most staff told us of the process, which they could access on the computer system, they would use to report them. However some reception and administration staff were not aware of the correct system of reporting. There was a significant event during the inspection, involving the reception staff and, whilst they understood the need to report it they were unsure of how to do so. This posed a risk that the practice might be unaware of incidents because they had been incorrectly recorded.

Staff reported events and there had been eight reports over the previous year. They were discussed at meetings and the minutes recorded. There was evidence of learning from events. For example there had been a clinical incident involving the prescribing of a medicine despite some contra-indications. This was investigated, discussed at a clinical meeting and a record made of how the learning was shared amongst relevant staff.

National patient safety alerts were dealt with by the practice manager. They were sent on to the GPs and nurses for clinical matters and other staff as necessary. We looked at two recent alerts and saw that they had been dealt with in accordance with the instructions within the alert. Alerts were discussed at clinical meetings.

Overview of safety systems and processes

The practice could demonstrate a safe track record through having systems for managing safeguarding, health and safety including infection control, medication management and staffing.

There were arrangements to safeguard vulnerable adults and children from abuse that reflected relevant legislation and local requirements. All the GPs were trained to the appropriate level (level three). There were policies which guided staff in safeguarding matters. There were notices directing staff who to contact in order to report such matters. There was a practice lead (a GP) for safeguarding and staff knew who this was. There were meetings held on alternate months, one to discuss safeguarding of children and one to discuss vulnerable adults. They were held at the practice and attended by GPs, social workers, school nurses and nurses from the community as appropriate. Staff told us of specific incidents that had been reported and investigated in accordance with local procedures.

There were notices in the waiting room, treatment rooms and consultation rooms advising patients that staff would act as chaperones, if required. Staff who acted as chaperones had received a disclosure and barring check (DBS). These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults.

There were processes for monitoring and managing risks to patients and staff. For example, there was a recent fire risk assessment. There had been a fire evacuation drill in June 2015. A fire warden had been trained and appointed for each floor of the practice building. There was a system governing security of the practice. Visitors were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied when patients were in the building. Doors to secure areas of the building were controlled using an electronic key pad.

All electrical equipment was checked to ensure the equipment was safe to use. Clinical equipment was checked to ensure it was working properly and calibrated in accordance with the manufacturers' instructions. The clinical equipment was marked with an expiry date sticker. All the equipment we saw had been checked within the appropriate timeframe.

The practice had a lead for infection control who was able to provide advice to the practice on infection control and carry out staff training. All the staff we spoke with knew who was the lead for infection control. Infection control policies and procedures were available to staff, to help enable them to plan and implement measures to mitigate the risks of infection. There were cleaning schedules and cleaning records were kept. Staff said that they had had updates to infection control training such as hand washing instruction, however the evidence to support this was not available. Annual infection control audits were undertaken and action had been taken to address any concerns. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We found the practice to be clean and well ordered.

Good

Are services safe?

Medicines in the treatment rooms, the dispensary and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure that medicines were kept at the required temperatures and which described the action to take in the event that this had not been achieved. There had been a recent incident involving the monitoring of refrigeration temperatures and the practice had responded quickly and correctly, taking expert advice from the relevant agencies and the manufacturers of the affected medicines.

Regular medicines and prescribing reviews were carried out with the support of the clinical commissioning group (CCG) help to ensure the practice was prescribing in line with best practice guidelines.

The practice had a policy that set out the standards for recruiting staff. We saw that appropriate recruitment checks had been undertaken prior to employment. We looked at staff files and saw that there was proof of identification, qualifications, registration with the appropriate professional body, as required, and that all staff had had criminal records checks via the DBS.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and there were emergency medicines available in various rooms within the practice. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency medicines we looked at were in date and checked regularly together with the emergency equipment. The practice had a defibrillator and medical oxygen with adult and children's masks.

There was a business continuity plan to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The plan contained current contact numbers for the various agencies who might need to be contacted in the event of an emergency and the details of surrounding practices who had agreed to assist in the event that the building was unavailable for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) guidelines and had systems to support clinical staff to keep up to date. The practice had access to guidelines from NICE. There was a specific system, covering the local clinical commissioning group (CCG) that provided guidance on local referral systems and pathways. This helped GPs and nurses keep up to date with the changing local referral pathways. The practice used this information to develop how care and treatment was delivered to meet needs. For example, the practice implemented NICE guidance by the use of a transcutaneous electrical nerve stimulation (TENS) machine as an adjunct to core treatments for pain relief.

Management, monitoring and improving outcomes for patients

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The results for the financial year ending March 2014 (the latest date for which results were available) were that the practice had attained a score of 98.6%.

This practice was not an outlier for any QOF (or other national) clinical targets. Performance for diabetes related indicators was better than the CCG and national average of 88% with 96% of patients receiving an annual review of their condition. Ninety four per cent of patients with hypertension who scored 'less than active' for physical activity had had some intervention such as advice on lifestyle. This followed NICE guidance and was considerably better than the local average of 89% and the national average of 91%.

The percentage of patients with dementia who had had a face to face review in the past year was 93% this was better than the CCG average of 85% and national average of 84%. This placed the practice in the top third in the country. In four of the last six years 100% of all mental health patients had had a care plan reviewed annually. This figure had fallen to 94% (still substantially above the national and local performance) in the last two years but this was when the practice had taken on an additional 4000 patients with a consequent increase of 55% in the number of mental health patients.

Much QOF data concerns the monitoring of patients with long-term conditions who require annual (or sometimes 15 monthly) checks to meet the guidance for the best management of their condition. Nationally and locally there has been a small decline in performance over the last two years. However the Clanricarde had not followed this tendency. Where national data showed a decline in monitoring of patients with conditions such as asthma, chronic obstructive pulmonary disease (COPD), mental health problems and chronic kidney disease the practice had improved its performance. These differences were marked. For example; over a three year period, in monitoring asthma the local performance had fallen from 78% to 72% where the practice had risen from 78% to 79%, for COPD the figures showed a local fall from 91% to 89% and a practice rise from 91% to 96%, for diabetes similar comparisons were 92% down to 88% against a steady practice figure of 96%.

The practice had conducted a number of audits. These had ranged from participating in medicines audits with the CCG, through a review of prescribing following the death of an asthma patient (not at this practice), to an audit of a birth control implant. Audits were well planned. Improvements were implemented following the audits for example a change in the template used for the birth control implant to help ensure that there was greater discussion of certain key areas between the patient and the GP. There were further audit cycles, conducted or planned, to check whether the improvements had been sustained.

GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice but had not received MCA training. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Staff were able to give several examples of how best interest meetings had been used to help decide the course action to be taken where patients lacked the capacity to decide for themselves.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Records showed that mandatory training such as information governance, basic life support and safeguarding had been completed by staff. The practice had identified gaps in training and was addressing them.

We noted a wide skill mix among the doctors with GPs having qualifications in child health, sexual and reproductive health, family planning and minor surgery. There were GPs with interests in holistic medicine, acupuncture and palliative care

All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager.

Coordinating patient care

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and other correspondence both electronically, by fax and by post. Staff knew their responsibilities in dealing with any issues arising from these communications. All the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system. There were systems to ensure that results were dealt with when staff, to whom they were addressed, were not there.

There were regular meetings with other providers, for example there were monthly multi-disciplinary meetings to discuss the needs of complex patients, such as 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 and treatment were documented.

There were trained counsellors, working within the practice, who provided improving access to psychological therapies (IAPT) services, these are talking therapies for patients with mild, moderate and moderate to severe symptoms of anxiety or depression. GPs could refer patients to the service or patients could self-refer. There was a monthly clinic with a local psychiatric community nurse and a monthly memory clinic for patients who might have dementia type symptoms. There were three midwifery clinics a month for mothers who were patients at the practice. There was an ultrasound clinic for patients from the Clanricarde and surrounding practices. There were dermatology clinics available through telemedicine so that more patients could have access to secondary consultant services locally (telemedicine is the remote delivery of healthcare services over the telecommunications infrastructure). There was a podiatry clinic, There were healthy weight clinics. The practice participated in the abdominal aortic aneurysm screening programme. There was acupuncture available for musculoskeletal pain and headaches.

Consent to care and treatment

Patients' consent to care and treatment was always obtained in accordance with legislation and guidance. The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded. A separate form was used to record consent to invasive procedures, such as birth control implants. There had been audits of records that helped to ensure that consent processes met the relevant guidance.

Health promotion and prevention

Patients who might be in need of extra support were identified by the practice. For example, as part of a national initiative to prevent unplanned admissions to hospital, the practice had identified the two per cent of patients who were most vulnerable. Each of these had an individual care plan and a GP allocated to their care. The practice discussed the care of these patients if they were admitted to hospital and supported them to try and avoid future admissions. Patients who were most in need of advice on matters such as a healthy diet, smoking and alcohol consumption were identified and sign posted to relevant services.

The practice's uptake for the cervical screening programme was 95.66%, which was markedly better than the national average of 81.7% and put the practice in the top 2% in the country. The practice's uptake for the cervical screening programme had bettered the national performance each year over the last nine years by between 14% and 17%.

Childhood immunisation rates for the vaccinations given were comparable to both CCG and national averages.

Good

Are services effective?

(for example, treatment is effective)

Patients with certain conditions are encouraged to have an influenza vaccination and the practice's results for this were: coronary heart disease 99% of identified patients, COPD 99.1%, Diabetes 97.4% and stroke patients 98.8%. All these results were above the national and CCG averages, often by as much as five or six percentage points. This achievement had been sustained, consistently bettering national performance over the last five years or more.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey. We spoke with patients and read the comment cards that patients had completed. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Patient confidentiality was respected. There was a private area where patients could talk to staff if they wished. There was a notice telling patients about this facility, though the notice was behind the reception desk so that patients would only be likely to see it after they had started their dealings with the reception staff. The waiting room and reception desk area was open plan and welcoming but this made it more difficult for staff to maintain confidential discussions with patients. Staff were aware of this and took account of it in their dealings with patients but there were no notices or barriers to discourage patients from approaching the reception desk when other patients were being dealt with.

All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms and it was not possible to overhear what was being said in them. The rooms were, where necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

The survey results showed that;

- 99% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and national average of 87%. When asked the same question about nursing staff the response was 95% compared to the CCG average of 93% and national average of 91%.
- 96% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%. When asked the same question about nursing staff 95% said the nurses were good at listening to them compared to the CCG average of 94% and national average of 92%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%. When asked the same question about nursing staff 100% said they had confidence and trust in the last nurse they saw were good at listening to them compared to the CCG average of 98% and national average of 97%.
- 87% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information showed patients responded positively to questions about their involvement in planning and making decisions about their care as well as treatment and generally rated the practice well in these areas.

Data from the national patient survey showed that

- 85% of practice respondents said the GP involved them in care decisions and 95% felt the GP was good at explaining treatment and results. The first result was marginally above the national average, the second significantly above it. When asked the same questions about nursing staff the results were 87% and 97%, both slightly above the national average. The first result was marginally above the national average, the second significantly above it.

Patient and carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access specific services such as those related to certain disabilities. There were notices in the patient waiting room and on the practice's website that directed patients to support groups and organisations for carers. Patients we spoke with, some of whom were also carers, said that the practice was very supportive of carers. The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of people who were carers.

The staff put alerts on the patient record system, that informed others when a patient had died so that they were able to respond in the most sympathetic manner. There was also information on the system about patients who

Good

Are services caring?

were challenging and those who were sensitive to certain issues. Reception staff therefore received good communication about how to tailor their responses to meet the needs of individual patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

The practice worked with the commissioners of services to improve outcomes for patients in the area. For example, the practice provided space for other providers to run mental health, memory and ultrasound clinics.

There was an active patient participation group (PPG) which met approximately every eight weeks and worked with the practice to improve services. For example, the PPG had been influential in pressing for improved telephone services. As a result of PPG suggestions the practice had installed a number of chairs in the waiting room that were easier to vacate, particularly for elderly of infirm patients. The PPG meetings were attended by the practice manager and a GP, usually the same GP. PPG members we spoke with felt that the group was well supported by the practice.

Services were planned and delivered to take into account the needs of different patient groups. There was an extended hour's surgery on two mornings and two evenings a week for patients who could not easily attend during the normal working day. There were longer appointments available for patients who needed them, for example patients with dementia, learning disability and those who used interpreters. There were home visits for patients who were unable to leave their home. There were toilet facilities for disabled patients.

Access to the service

Results from the National GP Patient Survey from July 2015 showed that patients' satisfaction with opening hours was 70% and this was in line with the clinical commissioning group (CCG), 74%, and national, 75%, averages. Seventy four per cent of respondents found it easy to get through to the practice by phone and this was the same as the CCG and national averages. Also 95% were able to get an appointment to see or speak to someone the last time they tried which is significantly better than the CCG, 88% and national, 85% average.

The practice's opening hours were between 8.30am and 6.30pm Monday to Thursday and 8.30am to 6pm on Friday. Extended hours surgeries were from 7am to 8am Tuesdays and Thursdays and 6.30pm to 7.30pm Wednesdays and Thursdays. There were urgent on the day appointments each morning and each afternoon for patients who had problems that could not reasonably wait until the next available bookable appointment. There was a duty GP each day to deal with these urgent appointments. The GPs worked collaboratively and surgeries would, if necessary, continue until all the patients who needed to be seen that day had been seen. Patients could make pre-bookable appointments with their own GP.

The practice had a system of registering homeless patients using the details of a local homelessness charity.

Listening and learning from concerns and complaints

There was a complaints policy which included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system in the form of leaflets, notices and material on the website.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However, they felt that if they had to make a complaint they would be listened to and the matter acted upon.

We looked at a log of all the complaints received in the last 12 months and found that they had been recorded, investigated and responded to within the timeframes demanded by the practice policies. Complainants received a written apology where appropriate. We listened to one complaint being dealt with and it was done fairly and with consideration for the complainant.

Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care. For example staff were reminded of the need to inform patients that their appointment may have changed to a different GP if the requested GP was away from the practice for some time. On another occasion the practice reviewed how it managed patients' expectations of referrals following a complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide a caring service for patients, to support patients in living a healthy lifestyle and to involve patients in their own care. The practice aimed to develop staff to help ensure that staff had the right training and skills and to carry out their duties competently. Many staff knew and understood this and their place in delivering it. Some did not and the practice acknowledged this was an area that needed improvement.

Governance arrangements

The practice had a governance framework which supported the delivery of the strategy and good quality care. In support of this there were policies and procedures that guided staff. These were available to them on the desktop on any computer within the practice. We looked at some of these including recruitment, chaperoning, safeguarding, bereavement and complaints. They were in date and reviewed when necessary. There was evidence that staff had read the policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there were lead GPs for finance, premises, Quality and Outcomes framework and compliance with regulation amongst other areas. There was a lead nurse for infection control and a GP lead to provide supervision and support for nursing staff.

The QOF data for this practice showed it was performing better than CCG and national standards often significantly so. QOF data was regularly discussed at team meetings and there were plans to maintain and improve outcomes.

The practice had completed an accreditation process with Health Education Kent, Surrey and Sussex (called the Deanery) to allow it to participate in the national programme of post-graduate training for doctors by offering a placement in a GP practice. This was an external test of the effectiveness of the governance processes.

Leadership, openness and transparency

The partners were visible in the practice and it was clear that there was an open culture within the practice. Staff had the opportunity, and were happy, to raise issues at team meetings. Staff told us that the GPs and management were approachable and took the time to listen.

There were regular team meetings. Minutes were kept and there was a structured agenda. Topics such as significant events, training and changes to practice policies were discussed. There were no meetings where the whole practice staff attended. Staff said they felt respected, valued and supported. For example, we saw that there was structured support for the new practice manager in acknowledgement of the wide reach of the job. The structured support included mentoring from an experienced practice manager and weekly supportive meetings with a partner.

Staff told us of occasions when they had made suggestions at staff meetings such as changes to working practices. The changes had been accepted or, where this was not possible, staff were told why. There was continuity in meetings, for example, the same GP, a partner, attended the all the nurses meetings.

Seeking and acting on feedback from patients, the public and staff

All staff were involved in discussions about how to run and develop the practice. The practice had recently carried out a very full assessment of the administration and reception functions at the practice. This had included consulting with staff on many aspects of their work. A report into the review had been delivered but there had not yet been time to act on it.

The practice encouraged and valued feedback from patients. Patients were asked to provide feedback through the practice's website, through the patient participation group (PPG) and through in house and other surveys such as the National GP Patient Survey. In collaboration with the PPG newsletters had been published and made available to patients physically or through the practice website. The newsletter sets out the areas for action that have been identified through these processes

Innovation

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring and we saw examples of mentoring of staff. Records showed that regular appraisals had taken place which included a personal development plans for appropriate staff. Staff were very positive about the practice's commitment to staff development and there were examples of staff progressing within the practice.

Are services well-led?

Good

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

Reception and administration staff both commented that they would like to know more about each other roles and some wanted the opportunity to work across both departments.

The practice was forward thinking and took part of local pilot schemes to improve outcomes for patients in the area. For example one of the GPs was leading on the establishment of a federation of GP practices in the area (a GP federation is a group of practices, within a geographical area, collaborating to provide a greater range of services). This had been set up and was seeking to be commissioned for a diabetic service that would bring many secondary diabetic services out of hospital and into the community.

The practice was a teaching practice and all the staff were to some degree involved in the training of doctors who were undertaking a GP placement as part of their training. The practice was subject to scrutiny by the Deanery as the supervisor of this training. Doctors on placements were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. GPs' communication and clinical skills were therefore regularly under review.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.