Amherst Medical Practice

Quality Report

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Date of inspection visit: 4 March 2015
Date of publication: 09/07/2015

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

Ratings

Overall rating for this service	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 of Amherst Medical Practice on 4 March 2015. 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 the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the patient population groups of; 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 and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.
- Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and training planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality.
- 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 needs. Information about how to complain was available and easy to understand.

Summary of findings

- 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. The patient participation group (PPG) was active.

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

The provider SHOULD;

- Ensure that all policies contain relevant information.
- Ensure maintenance of the vaccines cold chain is adequately monitored and recorded.
- Ensure that all staff training records are kept up to date.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Amherst Medical Practice had systems to monitor, maintain and improve safety and demonstrated a culture of openness to reporting and learning from patient safety incidents. The practice had policies to safeguard vulnerable adults and children who used services. They monitored safety and responded to identified risks. There were systems for controlling infection and medicines management. Sufficient numbers of staff with the skills and experience required to meet patients' needs were employed. There was enough equipment, including equipment for use in an emergency, to enable staff to care for patients. Staff were trained and the practice had plans to deal with foreseeable emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff at Amherst Medical Practice followed best practice guidance and had systems to monitor, maintain and improve patient care. There was a process to recruit, support and manage staff. Equipment and facilities were monitored and kept up to date to support staff to deliver effective services to patients. The practice worked with other services to deliver effective care and had a proactive approach to health promotion and prevention.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were satisfied with the care provided by Amherst Medical Practice and were treated with respect. Staff were careful to keep patients' confidential information private and maintained patients' dignity at all times. Patients were supported to make informed choices about the care they wished to receive and felt listened to.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was responsive to patients' individual needs such as language requirements and mobility issues. Access to services for all patients was facilitated in a wide variety of ways. There were routine appointments with staff at Amherst Medical Practice as well as telephone consultations and on-line services. Patients' views, comments and complaints were used by the practice to make improvements to the services patients received.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure with an open culture that adopted a team approach to the welfare of patients and staff at Amherst Medical Practice. The practice used a variety of policies and other documents to govern activity and there were regular governance meetings. The practice had a comprehensive governance system with individual GPs having designated specific responsibilities. There were systems to monitor and improve quality. The practice took into account the views of patients and those close to them as well as engaging staff when planning and delivering services. The practice valued learning and had systems to identify and reduce risk.

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. Patients over the age of 75 had been allocated a designated GP to oversee their individual care and treatment requirements. Patients were able to receive care and treatment in their own home from practice staff as well as district nurses and palliative care staff. There were care plans to help avoid older patients being admitted to hospital unnecessarily. Specific health promotion literature was available as well as details of other services for older people. The practice maintained a register of older patients living in nursing and residential homes. This helped enable the practice to identify these patients and prioritise the care they needed. The practice held regular multi-professional staff meetings that included staff who specialised in the care of older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Documents were available that guided staff specifically in the care of patients with long-term conditions. Service provision for patients with long-term conditions included designated clinics with a recall system that alerted patients as to when they were due to re-attend. The practice employed staff trained in the care of patients with long-term conditions. The practice maintained a register of patients with specific long-term conditions such as stroke and asthma. This helped enable the practice to identify these patients and prioritise the care they needed. The practice supported patients to manage their own long-term conditions. Specific health promotion literature was available.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Documents were available that guided staff specifically in the care of families, children and young people. Services for mothers, babies, children and young people at Amherst Medical Practice included designated midwives and health visitor care. The practice maintained a register of pregnant patients. This helped enable the practice to identify these patients and prioritise the care they needed. Specific health promotion literature was available. The practice held regular multi-professional staff meetings that included staff who specialised in the care of mothers, babies and children.

Summary of findings

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 practice provided a variety of ways this patient population group could access primary medical services. These included pre-bookable and book on the day appointments from 8am to 6.30pm each week day, on-line appointment booking and telephone consultations. There was also an on-line repeat prescription service. Specific health promotion literature was available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for caring for people living in vulnerable circumstances. The practice offered primary medical service provision for people in vulnerable circumstances in a variety of ways. Patients not registered at the practice could access services. Interpreter services were available for patients whose first language was not English. The practice maintained a register of homeless patients. This helped enable the practice to identify these patients and prioritise the care they needed. Specific health promotion literature was available. Specific screening services were also available.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for caring for people experiencing poor mental health (including people with dementia). This patient population group had access to psychiatrist and community psychiatric nurse services as well as local counselling services. The practice maintained a register of patients with specific conditions such as depression and dementia. This helped enable the practice to identify these patients and prioritise the care they needed. Specific health promotion literature was available. Patients on the mental health register received annual reviews to help ensure they were receiving the correct help and that any medicines they were taking remained appropriate and effective. The practice held regular multi-professional staff meetings that included staff who specialised in the care of patients experiencing poor mental health.

Summary of findings

What people who use the service say

During our inspection we spoke with three patients, all of whom told us they were satisfied with the care provided by the practice. They considered their dignity and privacy had been respected and that staff were polite, friendly and caring. They told us they felt listened to and supported by staff, had sufficient time during consultations and felt safe. They said the practice was well managed, clean as well as tidy and they did not experience difficulties when making appointments. Patients we spoke with reported they were aware of how they could access out of hours care when they required it as well as the practice's telephone consultation service.

We received no patient comment cards at this inspection.

We looked at the NHS Choices website where patient survey results and reviews of Amherst Medical Practice were available. Results ranged from 'among the best' for the percentage of patients who would recommend this practice, through 'better than average' for scores for consultations with doctors and 'average' for scores for consultations with nurses. Results were 'as expected' for scores for opening hours and the practice was rated 'among the best' for patients rating their experience of making an appointment as good or very good. 96 per cent of patients rated the overall experience of this practice as good or very good.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all policies contain relevant information.
- Ensure maintenance of the vaccines cold chain is adequately monitored and recorded.
- Ensure that all staff training records are kept up to date.

Amherst 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, a practice manager specialist advisor.

Background to Amherst Medical Practice

Amherst Medical Practice is situated in Sevenoaks, Kent and has a registered patient population of approximately 13,000 (6,500 male and 6,500 female). There are approximately 3,200 registered patients under the age of 19 years (1,600 male and 1,600 female), 8,500 registered patients between the age of 20 and 74 years (4,200 male and 4,300 female) and 1,200 registered patients over the age of 75 years (500 male and 700 female).

Primary medical services are provided Monday to Friday between the hours of 8.30am to 12.30pm and 2pm to 6.30pm at Amherst Medical Practice. Services are also provided at the Brasted Surgery Monday to Thursday 8.30am to 12.30pm and 2.30pm to 5pm as well as Friday 8.30am to 12.30pm. Primary medical services are available to patients registered at Amherst Medical Practice at either location via an appointments system. There is a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. There are arrangements with another provider (the 111 service) to deliver services to patients outside of Amherst Medical Practice's working hours.

The practice staff consisted of eight GP partners (three male and five female), one salaried GP (female) and one trainee GP (female), one practice manager, one nurse practitioner (female), six practice nurses (all female), two healthcare assistant (both female) as well as reception and administration staff. There is a reception and a waiting area on the ground floor. All patient areas are wheelchair accessible.

Services are provided from Amherst Medical Practice, 21 St Boltolph's Road, Sevenoaks, Kent, TN13 2RP and Brasted Surgery, High Street, Brasted, Kent, TN16 1HU.

Amherst Medical Practice is a training practice and dispenses medicines from its branch surgery only.

The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Why we carried out this inspection

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

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

This provider had not received a comprehensive inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England, the local clinical commissioning group and local Healthwatch, to share what they knew. We carried out an announced visit on 4 March 2015. During our visit we spoke with a range of staff (five GPs, the practice manager, one practice nurse and one receptionist) and spoke with three patients who used the service as well as the chair of the patient participation group.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example, reported incidents and accidents, national patient safety alerts as well as comments and complaints received.

There was a system to disseminate national patient safety alerts to practice staff.

Patients' records were in electronic and paper form. Records that contained confidential information were held in a secure way so that only authorised staff could access them.

Learning and improvement from safety incidents

There was a culture of openness to reporting and learning from patient safety incidents.

The practice had a system for reporting, recording and monitoring incidents, accidents and significant events. All staff we spoke with were aware of how to report incidents, accidents and significant events.

The practice had a system to investigate and reflect on incidents, accidents and significant events that occurred which was led by a designated GP. All reported incidents, accidents and significant events were managed by designated staff. Feedback from investigations was discussed at significant event meetings and staff meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to safeguard vulnerable adults and children who used services. There was written information for safeguarding vulnerable adults and children as well as other documents readily available to staff that contained information for them to follow in order to recognise potential abuse and report it to the relevant safeguarding bodies. For example, a safeguarding adults policy. Contact details of relevant safeguarding bodies were available for staff to refer to if they needed to report any allegations of abuse of vulnerable adults or children. The practice had a designated GP appointed as lead in safeguarding vulnerable adults and children trained to the appropriate level (level three). All staff we spoke with were aware of the designated appointed leads in safeguarding as well as the practice's safeguarding policies and other documents. Records demonstrated that staff were up to date with training in safeguarding. When we spoke with staff they were able to describe the different types of abuse patients may have experienced as well as how to recognise them and how to report them.

The electronic patient record system helped identify young people who were subject to child protection to staff.

The practice had a whistleblowing policy that contained relevant information for staff to follow that was specific to the service. The policy detailed the procedure staff should follow if they identified any matters of serious concern. Although the policy contained the names of external bodies that staff could approach with concerns, the policy did not contain contact details for these organisations. All staff we spoke with were able to describe the actions they would take if they identified any matters of serious concern and most were aware of this policy.

The practice had a monitoring system to help ensure staff maintained their professional registration. For example, professional registration with the General Medical Council or Nursing and Midwifery Council. We looked at the practice records of three clinical members of staff which confirmed they were up to date with their professional registration.

The practice had a chaperone policy and information about it was displayed in public areas informing patients that a chaperone would be provided if required. One patient we spoke with told us they were aware this service was available at the practice.

Medicines management

Amherst Medical Practice had documents that guided staff on the management of medicines such as a medicines management policy. Staff told us that they accessed up to date medicines information and clinical reference sources when required via the internet and through published reference sources such as the British National Formulary (BNF). The BNF is a nationally recognised medicines reference book produced by the British Medical Association and Royal Pharmaceutical Company. The practice received an annual prescribing review from the local clinical commissioning group and had an action plan to address points identified. One GP had lead responsibilities for medicines management and dispensing.

Good

Are services safe?

Medicines stored in the dispensary, treatment rooms and medicine refrigerators were stored securely and only accessible to authorised staff. Practice staff monitored the refrigerator as well as room storage temperatures and appropriate actions had been taken when the temperatures were outside the recommended ranges.

There were processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Records confirmed medicines held by the practice for use in emergency situations were checked regularly and the practice had a system to monitor and record all medicine stock levels. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had 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, access to them was restricted, and the keys held securely. Although the records were not fully compliant with the current regulations the practice had an action plan to change the way it recorded controlled drugs to help ensure they became fully compliant.

Nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. There were up-to-date copies of both sets of PGDs available for staff to refer to and records showed that nurses had received appropriate training to administer vaccines. There were also appropriate arrangements to enable nurses to administer medicines that had been prescribed and dispensed for patients. Although vaccines were transported to the branch surgery by staff in a cool bag, the temperature whilst in transit had not been monitored.

The practice had a system for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Staff told us that high risk medicines were not "on repeat" and when requested, a GP would generate the prescription, if appropriate. Whilst most prescriptions supplied medicines for 28 days, prescriptions of shorter durations were issued where clinically appropriate.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice. There were prescription security policies that guided staff to help maintain safe management of prescriptions. Although blank prescription forms were not handled consistently in accordance with national guidance, they were kept securely at all times.

Patients were able to obtain repeat prescriptions either in person, on-line or by completing paper repeat prescription requests. The practice had a system that helped ensure patients' medicines reviews were carried out at regular intervals and in response to changes in local and national guidance.

The practice participated in the Dispensing Services Quality Scheme (DSQS). Dispensing errors identified at the final checking stage or after collection were recorded, investigated, discussed and systems changed to reduce the risk of further errors.

The practice had established a service for patients to pick up their dispensed prescriptions at the main surgery and had systems to monitor when these medicines were collected. There was also a system that helped ensure patients collecting medicines from the main surgery were given all relevant information about their prescription medicine(s) being issued.

Cleanliness and infection control

The premises were generally clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control at Amherst Medical Practice.

The practice had infection control policy that contained procedures for staff to refer to in order to help them follow the Code of Practice for the Prevention and Control of Health Care Associated Infections. The code sets out the standards and criteria to guide NHS organisations in planning and implementing control of infection.

Good

Are services safe?

Nurses were provided with uniforms that were reviewed on an annual basis for replacement. There was also written guidance available for staff to follow on how frequently to wear a clean uniform as well as how to launder them in order to reduce the risk of cross infection.

The practice had an identified infection control lead. We spoke with five GPs and one nurse, all of whom told us they were up to date with infection control training. However, records were not available to confirm this.

The treatment and consulting rooms were clean, tidy and uncluttered. Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use.

Antibacterial gel was available throughout the practice for staff and patients to use. Antibacterial hand wash, paper towels and posters informing staff how to wash their hands were available at all clinical wash-hand basins in the practice.

The practice environment was not fully compliant with national guidance on infection control in the built environment. For example, some clinical wash-hand basins contained over flows and had plugs. There was, therefore, a risk of cross contamination when staff used them. However, the practice had an action plan to refurbish the premises and address these issues at that time.

There was a system, and a waste management protocol, for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, designated containers whilst awaiting collection from a registered waste disposal company.

Cleaning schedules were used and there was a supply of approved cleaning products. Records of domestic cleaning carried out in the practice were kept. Staff told us that they cleaned equipment such as an ECG machine (a piece of equipment used to monitor the electrical activity of a patient's heart), between patients but did not formally record such activity.

Infection control risk assessments were carried out in order to identify risks and implement plans to reduce them where possible. Infection control audits were also carried out to assess or monitor infection control activity at Amherst Medical Practice. Action plans had been developed to address any deficiencies identified by this audit activity.

The practice did not have a system for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). However, records showed that the practice had received advice from their boiler maintenance team that legionella testing was not required. Since our inspection the practice has developed an action plan that includes carrying out a more extensive legionella risk assessment to further reduce the risk of infection from 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 (including clinical equipment) was tested, calibrated and maintained regularly and there were equipment maintenance logs and other records that confirmed this. One GP had lead responsibilities for equipment provision and maintenance.

Staffing and recruitment

The practice had policies and other documents that governed staff recruitment. For example, a recruitment policy. Personnel records contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records.

Records demonstrated all relevant staff had Disclosure and Barring Service (DBS) clearance (a criminal records check) or an assessment of the potential risks involved in using those staff without DBS clearance.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice carried out regular analysis of appointments to help ensure their appointments capacity met patients' requirements. 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 keep patients safe.

Monitoring safety and responding to risk

Good

Are services safe?

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see and the practice had a designated health and safety representative.

A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Staff told us they had received fire safety training and records confirmed this.

Staff told us there were a variety of systems to keep them, and others, safe whilst at work. They told us they had the ability to activate an alarm via the computer system to summon help in an emergency or security situation.

There was a system governing security of the practice. For example, visitors were required to sign in and out using the designated book in reception. Some non-public areas of the practice were secured with coded key pad locks to help ensure only authorised staff were able to gain access.

Although none of the patient toilets at Amherst Medical Practice were equipped with alarms so that help could be summoned if required, the practice had an action plan to install alarms in patient toilets in advance of their next scheduled refurbishment.

Arrangements to deal with emergencies and major incidents

There were procedural documents that guided staff in the management of medical emergency situations such as cardiac arrest. Records confirmed that all staff were up to date with basic life support training. Emergency equipment was available in the practice, including access to emergency medicines, medical oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). Staff told us that these were checked regularly and records confirmed this.

There was a business continuity plan that guided staff to manage situations such as loss of the computer system or incapacity of GPs. This document also incorporated arrangements for staff to follow in order to manage the outbreak of an influenza pandemic.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice operated a clinical audit system that improved the service and followed up to date best practice guidance.

Staff had access to best practice guidance via the internet and access to specialists such as tissue viability nurses and stoma care nurses.

The practice worked with district nurses and palliative care services to deliver end of life care to patients. One GP had lead responsibilities for palliative care.

Management, monitoring and improving outcomes for people

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The 2013 / 2014 QOF data for this practice showed it was performing in line with national standards with the exception of one area. For example, the number of ibuprofen and naproxen items prescribed as a percentage of all non-steroidal anti-inflammatory drugs items prescribed was worse than average. However, the practice demonstrated that during the first six months of the 2014 / 2015 period significant improvements had been made in the QOF area that were previously worse than average. Records demonstrated that QOF results and improvement plans were discussed at staff meetings and shared with the patient participation group. One GP had lead responsibilities for QOF.

Staff told us the practice had a system for completing clinical audit cycles to help improve the service and follow up to date best practice guidance. The practice carried out analysis of these audit results, made action plans to address any issues identified and planned to repeat the audit to assess the impact of any actions taken and complete a cycle of clinical audit. Results of clinical audits were shared with relevant staff.

One of the GPs was designated lead responsibilities for information technology and data quality. An audit was in the process of being carried out to check the quality of information recorded in patients' clinic records, results of which were not yet available.

The practice worked closely with the local clinical commissioning group to help monitor the quality of the services Amherst Medical Practice provided as well as maintain and improve standards where necessary. One GP was a board member of the local clinical commissioning group (CCG).

Effective staffing

Personnel records we reviewed contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records.

Staff underwent induction training on commencement of employment with the practice. Staff told us that they received yearly appraisals and GPs said they carried out revalidation at regular intervals. Records confirmed this. There was evidence in staff files of the identification of training needs and continuing professional development needs.

The practice had processes to identify and respond to poor or variable practice including policies such as the bullying and harassment policy and the sickness absence policy.

Equipment and facilities were kept up to date to help ensure staff were able to deliver effective care to patients.

Working with colleagues and other services

The practice worked with midwives, health visitors and community nursing teams to deliver care to patients. Records confirmed that multidisciplinary meetings took place in order to discuss and plan patient care that involved staff from other providers.

The practice had a system for transferring and acting on information about patients seen by other doctors out of hours and patients who had been discharged from hospital.

The practice had a system to refer patients to other services such as hospital services or specialists. The practice monitored referrals to help ensure patients received appropriate appointments with other health professionals in a timely manner.

Staff told us that there was a system to review and manage blood results and other correspondence on a daily basis.

Good

Are services effective?

(for example, treatment is effective)

Results and correspondence that required urgent attention were dealt with by the duty GP at the practice promptly, and out of hours doctors as well as palliative care staff were involved when necessary.

Information sharing

Relevant information was shared with other providers in a variety of ways to help ensure patients received timely and appropriate care. For example, staff told us the practice met regularly with other services, such as district nurses, to discuss patients' needs.

The practice had a system to alert the out of hours service or duty doctor to patients dying at home.

All information about patients received from outside of the practice was captured electronically in the patients' records. For example, letters received were scanned and saved into the patients' records by the practice.

Consent to care and treatment

The practice had a consent protocol 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.

Staff told us that they obtained either verbal or written consent from patients before carrying out examinations, tests, treatments, arranging investigations or referrals and delivering care. They said that parental consent given on behalf of children was documented in the child's medical records. Staff had received training on the Mental Capacity Act 2005. Staff we spoke with were able to describe how they would manage the situation if a patient did not have capacity to give consent for any treatment they required. Staff also told us that patients could withdraw their consent at any time and that their decisions were respected by the practice.

Health promotion and prevention

There was a range of posters and leaflets available in the reception / waiting area. These provided health promotion and other medical and health related information for patients such as prevention and management of shingles as well as details of organisations that offered services to people at risk of falls.

The practice maintained a register of patients from all patient population groups with specific conditions such as stroke and learning disabilities. This helped enable the practice to identify these patients and prioritise the care they needed.

The practice provided designated clinics for patients with certain conditions such as diabetes and asthma. Staff told us these clinics helped enable the practice to monitor the on-going condition and requirements of these groups of patients. They said the clinics also provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration. Patients who used this service told us that the practice had a recall system to alert them when they were due to re-attend these clinics.

Patients told us they were able to discuss any lifestyle issues with staff at Amherst Medical Practice. For example, issues around eating a healthy diet or taking regular exercise. One patient told us that the practice had recently worked with a charity, giving them dietary advice on the contents of Christmas food parcels. Patients said they were offered support with making changes to their lifestyle. For example, referral to a smoking cessation service.

Staff told us new patients were offered health checks when they registered with Amherst Medical Practice. Sexual health advice was available to all patients and literature was accessible on local sexual health services. Staff told us they offered appropriate opportunistic advice, such as breast self-examination and testicular self-examination, to patients who attended the practice routinely for other issues.

The practice provided childhood immunisations, seasonal influenza inoculations and relevant vaccinations for patients planning to travel overseas. Seasonal influenza inoculations were also provided to older patients living in local care and residential homes by nurses from Amherst Medical Practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Amherst Medical Practice had a confidentiality policy as well as information governance policies that guided staff and helped ensure patients' private information was kept confidential.

We spoke with three patients, all of whom told us they were satisfied with the care provided by the practice. All patients we spoke with considered their dignity and privacy had been 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 whilst they undressed / dressed and 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.

Incoming telephone calls answered by reception staff and private conversations between patients and reception staff that took place at the reception desk could be overheard by others. However, when discussing patients' treatments staff were careful to keep confidential information private. Staff told us that a private room was available should a patient wish a more private area in which to discuss any issues and there was a sign that informed patients of this.

Care planning and involvement in decisions about care and treatment

Patients told us health issues were discussed with them and they felt involved in decision making about the care and treatment they chose to receive. Patients told us they felt listened to and supported by staff and had sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive.

Results available on the NHS Choices website taken from the 2013 GP patients surveys ranged from 'among the best' for the percentage of patients who would recommend this practice, through 'better than average' for scores for consultations with doctors and 'average' for scores for consultations with nurses. Results were 'as expected' for scores for opening hours and the practice was rated 'among the best' for patients rating their experience of making an appointment as good or very good. 96 per cent of patients rated the overall experience of this practice as good or very good.

Patient/carer support to cope emotionally with care and treatment

Timely support and information was provided to patients and their carers to help them cope emotionally with their care, treatment or condition. Support group literature was available in the practice such as support for patients with long-term conditions and information about support available to carers.

The practice supported patients to manage their own health, care and wellbeing and to maximise their independence. Specialised clinics provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

An interpreter service was available for patients whose first language was not English.

Patients over the age of 75 years had been allocated a designated GP to oversee their individual care and treatment requirements. Staff told us that patients over the age of 75 years were informed of this by letter. Specific health promotion literature was available as well as details of other services for older people. The practice held regular multidisciplinary staff meetings that included staff who specialised in the care of older people.

The practice had a GP designated to the care of patients who lived in local nursing and residential homes which enhanced continuity of care for these patients. There was also a GP designated to the care of patients with learning disabilities living in designated accommodation locally.

The practice employed staff with specific training in the care of all patient population groups. For example, one nurse had received specific training in adult, child and travel vaccination.

Patients were able to receive care and treatment in their own home from practice staff as well as community based staff such as district nurses and palliative care staff. Individual GPs had designated responsibilities for palliative care and the health of children at Sevenoaks School.

Specific health promotion literature was available for all patient population groups such as information about The Alzheimer's Society for patients worried about their memory, details of a Diabetes UK one day event, information about local child health drop in clinics, availability of free NHS health checks, details of the shared lives service available to vulnerable adults and contact details of support organisations for patients requiring psychological support.

Patients told us they were referred to other services when their condition required it. For example, one patient told us they were referred to the local hospital for treatment that the practice was not able to provide locally.

There was information available in the waiting area about services offered by other providers such as an out of hours dental service and a local Christian counselling service as well as contact details for the British Red Cross equipment loan service. Staff external to the practice provided midwifery services, counselling services and physiotherapy services at Amherst Medical Practice.

Tackling inequity and promoting equality

All patient areas of the practice were accessible by wheelchair.

Amherst Medical Practice had an equality and diversity policy that guided staff. Records showed that some staff had received training in equality and diversity. Services were delivered in a way that took into account the needs of different patients on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

The practice maintained registers of patients with learning disabilities, depression and dementia that assisted staff to identify them to help ensure their access to relevant services. Patients on the mental health register received annual reviews to help ensure they were receiving the correct help and that any medicines they were taking remained appropriate and effective.

Access to the service

Primary medical services were provided at Amherst Medical Practice Monday to Friday between the hours of 8am and 6.30pm. Primary medical services were available to patients registered at Amherst Medical Practice via an appointments system, including patients that were homeless. Staff told us that patients could book pre-bookable or on the day appointments by telephoning the practice, using the on-line booking system or by attending the reception desk in the practice. The practice provided a telephone consultation service for those patients who were not able to attend the practice. The practice carried out home visits if patients were housebound or too ill to visit Amherst Medical Practice. There was a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. There were arrangements with another provider (the 111 service) to deliver services to patients outside of Amherst Medical Practice's working hours.

The practice opening hours as well as details of how patients could access services outside of these times were available on the practice website. They were also displayed on the front of the building and were available for patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

to take away from the practice in written form. For example, in a practice leaflet. The practice also produced a regular newsletter that informed patients of new developments at Amherst Medical Practice and other related issues.

Patients we spoke with said they experienced few difficulties when making appointments.

Contact information was available that enabled patients to refer themselves to the mental health service without the need to make an appointment with a member of staff at the practice. Patients with a known mental health issue had a designated GP allocated to oversee their care and treatment at Amherst Medical Practice.

Listening and learning from concerns and complaints

Amherst Medical Practice had a system for handling complaints and concerns. Their complaints protocol was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. There was also a designated GP with specific responsibilities for complaints. Timescales for dealing with complaints were clearly stated and details of the staff responsible for investigating complaints were given. There was a leaflet available for patients that gave details of the practice's complaints procedure that included the names and contact details of relevant complaints bodies that patients could contact if they were unhappy with the practice's response. Patients we spoke with were aware of the complaints procedure but said they had not had cause to raise complaints about the practice.

Records showed that the practice had received six complaints since January 2015 and had acknowledged as well as resolved the complaints within the timescale stipulated in the complaints protocol.

Staff told us that complaints were discussed at complaints meetings and staff meetings. Records confirmed this and demonstrated that learning from complaints and action as a result of complaints had taken place.

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

Amherst Medical Practice had a statement of purpose, as well as a mission statement, that stated that the practice aimed to provide high quality personalised patient care. This was to be achieved through good communication and individual doctor patient relationships, combined with the strength and depth provided by a group of doctors working together in a modern practice. Staff we spoke with were aware of the practice's statement of purpose and mission statement.

The practice also had a business development plan that supported and helped maintain their statement of purpose and mission statement. It also set out how enhancements to services were to be achieved.

Governance arrangements

There were documents that set out Amherst Medical Practice's governance strategy and guided staff. For example, a governance policy and a document entitled clinical governance good medical practice. There was a GP designated as clinical governance lead. Governance issues were discussed at lunchtime meetings and practice business meetings. Staff told us that relevant clinical governance issues were discussed and shared with the wider staff group at staff meetings and records confirmed this. There were a variety of policy, protocol, procedure and other documents that the practice used to govern activity. For example, the chaperone policy, the waste management protocol, the prescription recording procedure as well as the business continuity plan. The practice had a system to review these documents annually or sooner if changes in legislation or other guidance indicated. We looked at 20 such documents and saw that only one was out of date.

The practice had a comprehensive governance system with individual GPs designated as leads in safeguarding, medicines management, dispensing, palliative care, complaints as well as health and safety. Other responsibilities were distributed between GPs such as business and finance lead, GP trainer, nurse mentor, patient participation group link, the building environment, equipment provision and maintenance, information technology and data quality, Quality and Outcomes Framework data as well as Sevenoaks School link.

The practice carried out clinical audit cycles that improved the service and followed up to date best practice guidance. The practice carried out analysis of these audit results, made action plans to address any issues identified and planned to repeat the audit to assess the impact of any actions taken and complete a cycle of clinical audit. Records showed that results of clinical audits were shared with relevant staff.

Leadership, openness and transparency

There was a leadership structure with an open culture that adopted a team approach to the welfare of patients and staff. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care.

The practice demonstrated effective human resources practices such as comprehensive staff induction training. Staff told us that they received yearly appraisals and GPs said they carried out relevant appraisal activity that now included revalidation with their professional body at required intervals and records confirmed this. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).There was evidence in staff files of the identification of training needs and continuing professional development.

Staff had job descriptions that clearly defined their roles and tasks whilst working at Amherst Medical Practice. The practice had processes to identify and respond to poor or variable practice including policies such as the bullying and harassment policy.

Staff told us they felt well supported by colleagues and management at the practice. They said they were provided with opportunities to maintain skills as well as develop new ones in response to their own and patients' needs.

The practice was subject to external reviews, such as a prescribing review carried out by the local clinical commissioning group (CCG). GP revalidation involved appraisal by GPs from other practices.

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

Are services well-led?

Good

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

The practice took into account the views of patients and those close to them via feedback from the patient participation group (PPG), patient surveys, as well as comments and complaints received when planning and delivering services.

Minutes of the PPG meetings demonstrated regular discussions where comments and suggestions were put forward by members. Staff told us that comments and suggestions put forward at these meetings were considered by the practice and improvements made where practicable. The practice had a GP designated to supporting and working with the PPG.

In response to patients' feedback the practice had installed a notice board dedicated to PPG activities.

The practice monitored comments and complaints left in reviews on the NHS Choices website. Two reviews had been left on this website. One was positive and one was negative.

There were a variety of meetings held in order to engage staff and involve them in the running of the practice. For example, clinical meetings, nurses' meetings, multidisciplinary meetings, reception staff meetings and staff meetings. Staff we spoke with told us they felt valued by the practice and able to contribute to the systems that delivered patient care.

Management lead through learning and improvement

The practice valued learning. There was a culture of openness to reporting and learning from patient safety incidents. All staff were encouraged to update and develop their knowledge and skills. All staff we spoke with told us they had an annual performance review and personal development plan.

The practice had a system to investigate and reflect on incidents, accidents and significant events that occurred which was led by a designated GP. All reported incidents, accidents and significant events were managed by designated staff. Feedback from investigations was discussed at significant event meetings and staff meetings.

The practice was a training practice and all the staff were to some degree involved in the training of future GPs. The quality of GP registrar decisions was therefore under near constant review by their trainers. The practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. Registrars 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.

The practice demonstrated that they had systems to identify and reduce risk.