Westerham Practice

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.

Summary of findings

Contents

Summary of findings

Overall summary

The Westerham Practice covers much of the North Downs area. The practice is based at two main centres, Winterton Surgery just off Market Square Westerham and The Medical Centre on the main road in Sundridge.

The locations inspected were the Winterton Surgery at Russell House, Market Square, Westerham and the branch surgery located at The Medical Centre at 173 Main Road, Sundridge, Sevenoaks. The medical centre has a fully stocked dispensary and qualified dispenser. All patients who live more than a mile from a local pharmacy are able to choose to have their medicines dispensed to them at the surgery, or at their homes if the doctor is visiting. Arrangements can be made for the housebound to have their repeat medication delivered.

The practice was responsive to patients' needs. Staff had access to appropriate equipment, training, guidance and support. Staff had access to information about patients to support clinical decisions so that they could deal effectively with patients' needs. The provider had satisfactory systems in place to protect patients from the risk of abuse and ensure they received the appropriate care and treatment.

Staff told us they felt supported and the practice was well-led. There was a clear governance structure in place and regular team meetings to ensure that information was cascaded to all team members. We found that annual appraisals were undertaken for all staff, however, there were limited opportunities for staff to formally discuss issues relating to their work in a one to one meeting.

We found the practice was effective in meeting a wide range of patients' needs. Patients told us that they were happy with the care they received and that they were involved in decisions about their care. We were told staff were polite and respectful and we observed this to be the case. The practice carried out regular satisfaction surveys to capture patients' views.

During our inspection we spoke with 25 patients. Without exception patients were complimentary about the care they received and told us that staff were helpful, knowledgeable and that they felt safe and well cared for. However, patients repeatedly complained that there was a long wait for appointments if they wished to see their own doctor.

We saw that the practice proactively identified patients and their carers who may need on-going support. The practice provided home visits for those who were housebound or too ill to visit the surgery. There were district nurses attached to the practice who were available to give nursing care to patients in their homes. The practice had a named GP who visited 26 patients on a weekly basis at a local residential home.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice provided safe and suitable care to protect people from avoidable harm and abuse. Staff were aware of the policies and procedures in place for reporting concerns and safeguarding of vulnerable adults and children. Staff had received training in safeguarding children and adults. The practice had undertaken an analysis of five significant events in the last 12 months where learning points and actions had been recorded.

Medicines kept on the premises at Winterton Surgery were stored appropriately and securely. However, dispensary room temperatures at Sundridge were not monitored which posed a risk that medicines could have been stored at higher temperatures than recommended by the manufacturer. Staff were aware of emergency procedures and knew where the resuscitation equipment was kept.

Are services effective?

The practice was managed effectively. We found that the practice had systems in place to ensure that they could effectively respond to the needs of the patients accessing the surgery. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining 'good practice' in their surgeries. The QOF data for this practice showed that it was performing in line with the national average. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to ensure continuity of care.

Are services caring?

The practice was caring. The practice carried out regular satisfaction surveys to capture patients' views. The patients we spoke with and the feedback cards we reviewed were very positive about the care patients received. Patients told us that staff were kind, caring and respectful throughout the episode of care that they had received.

Are services responsive to people's needs?

The practice was responsive to patient's needs. There were mechanisms in place to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided and they were listened to and actions had been taken to make changes where practicable to do so.

Summary of findings

Are services well-led?

The practice was well led. Staff told us that they felt supported and that the practice was well-led. There were regular team meetings to ensure that information was cascaded to all staff team members. This included learning from incidents and any changes to practice across the organisation. There was a complaints policy and procedure in place as well as a process for escalating incidents to senior managers. All complaints and incidents were reviewed through clinical meetings. Although there were a number of processes in place, there was little documented evidence and no overarching policy for the ratification of all the policies used at the practice.

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

The practice proactively identified patients and their carers who may have needed on-going support. The practice provided visits for those who were housebound or too ill to visit the surgery. There were district nurses attached to the practice who were available to give nursing care to patients in their homes. The practice had a named GP who visited 26 patients on a weekly basis at a local residential home.

People with long-term conditions

We saw that the practice provided diabetic, weight management and asthma clinics that were run by the nurses and health care assistants in conjunction with the doctors. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

Mothers, babies, children and young people

The health visitors were closely involved in the healthcare of patients, particularly children. They attended the baby clinic at the Sundridge practice and Westerham village hall. Antenatal and postnatal care was carried out by both the doctors and midwives. A full range of family planning services were offered by the practice.

The practice offered an immunisation programme for babies and pre-school age children. There was a dedicated GP responsible for overseeing the primary care needs of children at a young disabled person's school. These children's physical health needs were regularly assessed and care was provided based on the results of those assessments.

The working-age population and those recently retired

The practice offered extended hours during the evenings and early morning, each week at the Westerham site. This was primarily for patients who found it difficult to attend during working hours.

Medical examinations for special purposes, for example, life insurance, school entrance, elderly drivers, pre-employment, fitness to undertake sports and fitness to travel were undertaken at both surgeries. The practice nurses were available to offer medical advice regarding travel and to vaccinate where appropriate

All smokers aged 15 years and above were offered smoking cessation advice.

Summary of findings

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

The practice told us it did not have specific groups of patients in vulnerable circumstances such as travellers, homeless people or asylum seekers. However, staff had access to interpreters and information in different languages. In addition, there was an agreed policy that the practice would use its own address for anyone that was homeless to ensure they were able to receive appropriate care and support. There was access to a loop for people who had a hearing impairment and, if required, they would contact a local service for signing.

Patients with learning disabilities (excluding children) were assessed by the nurse practitioner and an annual review was undertaken of their physical, psychological and social circumstances.

People experiencing poor mental health

There was a practice register for patients with dementia. We found that GPs had a high awareness of dementia and carried out 'opportunistic' and 'at risk' screening for patients with dementia. Patients with depression were seen within two weeks of their diagnosis and had regular follow ups thereafter.

Patients and those close to them were supported to receive emotional support from suitably trained staff if they needed it. Counsellors were available at the practice and patients were normally referred to them by the doctors. The practice also kept an up to date list of telephone numbers for counselling services and the crisis team.

Summary of findings

What people who use the service say

During our inspection we spoke with 25 patients. Without exception patients were complimentary about the care they received and told us that the staff were helpful, knowledgeable and they felt safe and well cared for. However, patients repeatedly complained that there was a long wait for appointments if they wished to see their own doctor and stated that appointments always took a week.

We looked at 10 completed comment cards. The majority of comments we received were positive. Some patients said they had used the practice for a long period of time and they were satisfied with their care. Patients said the staff always did their best and the premises were hygienic, safe and great in every way. There was a comments box in the main reception to encourage patient feedback. We saw that there were lots of cards and letters of thanks from patients, their families and carers to the staff.

Areas for improvement

Action the service COULD take to improve

- The practice should ensure that there are formal ratified governance policies in place.
- The practice could review access for urgent appointments to see a GP.

Westerham Practice

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a Care Quality Commission lead inspector. The team included a GP and other Care Quality Commission inspectors including a pharmacist and expert by experience.

Background to Westerham Practice

The Westerham Practice covers much of the North Downs area, from Limpsfield to Riverhead/Dunton Green and Halstead, and Westerham/Biggin Hill to Marlpit Hill, including many small villages, Toys Hill, Ide Hill, Crockham Hill, Brasted and Tatsfield. The practice is responsible for providing primary care to Westerham and the surrounding areas and has a population of approximately 8,200 residents. The practice serves an area with low deprivation and an average percentage of the practice population is in the 65 and over age group.

The practice is based at two main centres, Winterton Surgery at Russell House, Market Square, Westerham and the branch surgery located at The Medical Centre at 173 Main Road, Sundridge, Sevenoaks.

Why we carried out this inspection

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

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting the practice, we reviewed a range of information that had been collected by Care Quality Commission's Intelligence Monitoring team.

We inspected the practice as part of our new inspection programme for GP services. We carried out an announced visit on 15 May 2014.

We spoke with staff and patients who used the practice. We carried out a number of interviews with senior staff for example three doctors, a practice manager, a senior nurse practitioner, three nurses and four clerical staff.

During the inspection we reviewed policies and procedures that had been put in place so that the practice could monitor the quality of the service they provided.

Detailed findings

We observed how staff handled calls for repeat prescriptions or appointments.

Comment cards were given to the practice prior to the inspection to assess patients views about the care they received and some stakeholders were contacted as part of the inspection process.

Are services safe?

Summary of findings

The practice provided safe and suitable care to protect people from avoidable harm and abuse. Staff were aware of the policies and procedures in place for reporting concerns and safeguarding of vulnerable adults and children. Staff had received training in safeguarding children and adults.

The practice had undertaken an analysis of five significant events in the last 12 months where learning points and actions had been recorded.

Medicines kept on the premises were stored appropriately and securely. Staff were aware of the emergency procedures and were aware of where the resuscitation equipment was kept.

We found that the dispensary room temperatures at Sundridge were not monitored, although known to get hot especially in the summer months. Therefore, medicines may have been stored at higher temperatures than recommended by the manufacturer.

We found the premises to be modern, clean and tidy, although one treatment room and one consultation room where blood samples were taken on a regular basis had carpet on the floor this looked clean and unstained.

Our findings

Safe patient care

We found that the practice nurse and dispensers attended practice clinical meetings at which prescribing and dispensing errors were discussed. We saw that in September 2013 the practice had an annual prescribing review by NHS West Kent Clinical Commissioning Group (CCG). The aim of the visit was to enable the practice to discuss reporting and prescribing indicators and to highlight practice achievement and identify areas where practice needed improvement. This ensured that performance was consistent over time and where concerns had arisen they were addressed in a timely way. For example, past safety performance, and/or medicine errors.

The review found the practice had a higher than average number of prescriptions for non-steroidal anti-inflammatory drugs (NSAIDs). We spoke with one of the General Practitioners (GP) about this and clinicians in the in the practice were aware of the potential side effects of NSAIDs and there was a NSAIDs Prescribing Policy in place. The GP stated that the prescribing of one particular NSAID had decreased due to the increased awareness of side effects. Patients were encouraged to purchase some anti-inflammatory pain relieving tablets over the counter (unless entitled to free prescription). We were told that patients were encouraged to use NSAIDs for as short a term as possible and they had all been made aware of the potential serious complications, such as perforated/ bleeding stomach ulcers. Therefore, there were clearly defined and embedded systems and processes in place that reflected national and professional guidance in order to protect patients.

Learning from incidents

The practice had a serious incident policy in place. There was a flowchart to assist staff to make a decision as to whether an incident was 'serious' or not. We discussed significant event reporting with the practice manager. They told us that a form would be completed and the incident discussed with them. The incident would then be discussed at partnership and staff meetings. We saw that the practice had undertaken an analysis of five significant events in the last 12 months where learning points and actions had been taken and recorded.

Are services safe?

Safeguarding

The practice had policies and procedures for safeguarding vulnerable adults and children which included contact details of the local safeguarding teams. A named GP was identified as the safeguarding lead. Staff we spoke with had received safeguarding training and knew how to report any concerns. There was a whistle-blowing policy and staff we spoke with were able to tell us how they would recognise and report abuse.

Monitoring safety and responding to risk

There were processes in place and meetings to discuss governance issues relating to safety. We spoke with the practice manager who told us that a risk assessment had been undertaken about two to three months before our inspection to evaluate risk assessments for rooms, in particular around computer equipment, furniture and workstations. The practice manager told us that risk training was available on line, however, only the senior receptionist had been trained to evaluate risk assessments for rooms, and the practice was considering whether other staff should be trained.

There were emergency treatment arrangements, including emergency medicines, a defibrillator and access to medical oxygen. Staff had received training in responding to emergencies. Records showed that the emergency medicines were checked on a monthly basis.

Medicines management

The Westerham Practice stored vaccines and had medicines for emergency situations. We saw that the practice had in place and followed guidelines for maintaining the vaccine cold chain so that the viability of vaccinations could be assured. We found that medicines and vaccines were stored securely in an area accessed only by designated staff. There were processes in place for checking that all medicines and vaccines were accounted for. We saw that the appropriate temperature checks for the refrigerators used to store medicines had been carried out and all medication and vaccines were stored at the correct temperature.

The Medical Centre at Sundridge had a fully stocked dispensary and qualified dispenser. The dispensary room temperatures at Sundridge were not monitored which posed a risk that medicines could have been stored at higher temperatures than recommended by the manufacturer.

We saw that staff would not generate repeat prescriptions post review dates and would refer the request to the GP to ensure patients were reviewed. When generating repeat prescriptions against repeat requests, clerical staff monitored for over and under use.

Cleanliness and infection control

We found the premises at both practices to be modern, clean and tidy. Patients told us they always found the practice to be clean and had no concerns over cleanliness or infection control. We saw that the practice had completed infection control audits and action plans were in place for monitoring.

The nurse practitioner was the infection control lead and when we spoke with them they understood their role and responsibilities. Staff we spoke with told us they had been trained in infection control and the staff training records confirmed this.

The practice had an Infection Control Policy that outlined the procedures for staff to follow to ensure that the Code of Practice for the Prevention and Control of Health Care Associated Infections was implemented. The code sets out the standards and criteria to guide NHS organisations in planning and implementing infection control measures.

The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with personal protective equipment including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available throughout the practice for staff and patients to use and antibacterial hand wash, gel and paper towels were available throughout the practice. We saw that all instruments were single use only. Therefore, the risks associated with the spread of infection had been minimised.

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

Staffing and recruitment

Personnel records we reviewed contained evidence that the appropriate checks had been completed before staff

Are services safe?

commenced employment, including those with the Disclosure and Barring Service (DBS) (previously known as Criminal Records Bureau (CRB) to help ensure that people who used the service were protected.

We spoke with the practice manager about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. They showed us the systems they used to arrange rotas for all the different staffing groups to ensure they had enough staff on duty to meet the needs of patients.

Dealing with Emergencies

All staff at the practice were trained in emergency life support. This was updated annually. We saw that the practice had ensured reception staff had protocols in place to summon the emergency services if required. There were emergency treatment arrangements, including emergency medicines, a defibrillator and access to medical oxygen. Staff had received training in responding to emergencies. Records showed that the emergency medicines were checked on a monthly basis.

Equipment

Staff told us that they had adequate equipment to enable them to carry out diagnostic examinations and treatment. This included equipment and medicines to ensure that staff were able to provide the appropriate assessment and treatment to patients. We saw that equipment was checked and serviced as per manufacturers' guidelines.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was managed effectively. We found that the practice had systems in place to ensure that they could effectively respond to the needs of the patients accessing the surgery. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining 'good practice' in their surgeries. The QOF data for this practice showed that it was performing in line with the national average. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to ensure continuity of care.

Our findings

Promoting best practice

Patients with dementia were invited for an annual review or when patients presented at the practice to see a GP for other complaints, reviews were done following the Quality and Outcomes Framework (QOF) template for dementia. Therefore, care and treatment was delivered in line with recognised best practice standards.

We saw evidence that the practice operated a clinical audit system to improve the service and provide the best possible outcomes for patients. For example, a review of cancer diagnoses at Westerham Practice and an audit of adherence to the palpitations pathway for cardiology symptoms such as angina, as recommended by the Greater Manchester and Cheshire Cardiac and Stroke Network.

We were told that staff had received training in the Mental Capacity Act 2005 and training records we saw confirmed this. Staff we spoke with told us that they had been involved in discussions about the MCA 2005 and they were able to demonstrate their understanding of the legislation.

Management, monitoring and improving outcomes for people

The practice used the Quality and Outcomes framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining 'good practice' in their surgeries. The QOF data for this practice showed that it was performing in line with the national average. We spoke with the practice manager who told us that if the performance of the practice fell below national average, this would be discussed at partnership meetings and processes put in place to address any concerns. We found that care and treatment was delivered in line with recognised best practice standards. We saw that the nurse practitioner had designed a Quality and Outcomes Framework (QOF) year planner for 2014-2015 in order to improve access and care for patients with asthma, chronic obstructive pulmonary disease (COPD), diabetes mellitus, rheumatoid arthritis, epilepsy and chronic kidney disease (CKD). The plan involved sending invitation letters to patients with the conditions mentioned above for review at various times of the year. At the time of our review, a monthly audit was being undertaken to monitor the uptake of the invitations.

Are services effective?

(for example, treatment is effective)

We spoke with a GP about the care of patients with cancer. The GP told us that patients who were newly diagnosed were reviewed by GPs in the practice but there was no specific 'cancer review appointment' offered by the practice. GPs we spoke with were aware of the 'two week wait' around suspected cancer referral.

Patients who had undergone tests and were waiting for the results would be given a slip for when to call into the practice. If the results were clearly abnormal and worrying, then reception staff would be asked to contact the patient to make an appointment or the GPs would call the patient themselves.

Staffing

The practice manager told us that the practice actively encouraged staff development for the benefit of the practice and patients. We were told by some staff that they had recently been supported to undertake a national qualification for Knowledge and Skills in Primary Care (KaSPaC) in administration and supervising skills. A member of staff told us that after completing an KaSPaC they had recently been appointed as a healthcare assistant (HCA).

Staff were qualified for their roles. We saw examples of the staff induction training. There was a training matrix on one computer, however, there was no training/development policy that stipulated how often mandatory training should be undertaken. We were told that if staff identified a course they would like to attend, they would be asked to write out why it would be useful to attend the course and what impact it would have on patient care. The GPs would discuss training needs at a partnership meeting and how this would support patient care. If due to cost or accessibility a course was not agreed, they would look at other local courses to meet the needs of staff and patients.

Staff told us that they regularly had informal one to one meetings, however, there was no documented evidence to show this had happened. They told us that they had informal peer review groups and worked closely with the GPs and received on going feedback, however, there was no documented evidence to support this.

Yearly appraisals had taken place and staff we spoke with confirmed that they received these. There was evidence in staff files of the identification of learning needs and continuing professional development (CPD).

Working with other services

The practice had a named GP who visited 26 patients on a weekly basis at a local residential home. Patients from the home underwent medical and medication reviews up to twice a year (when appropriate) depending on their conditions.

We spoke with nursing staff who told us that they regularly worked in the community to provide care for patients who needed palliative or end of life care. They told us that they liaised with the local hospice through clinical meetings and shared information. Staff said the GPs at the practice had good relationships with the families of patients who were receiving end of life care.

We saw evidence of regular meetings which were held with other providers. For example, local healthcare commissioning groups, midwives, health visitors, and community nursing teams as well as social services, when relevant, to share information about patients and their care. This ensured that there was a multidisciplinary approach to providing care for patients.

Health, promotion and prevention

We saw that the practice had a range of patient information leaflets in the waiting area. A practice booklet was also available either in paper form or electronically from the practice's website. Information included details of cervical screening clinics, family planning clinics, child health and immunisation.

The practice provided diabetic, weight management and asthma clinics that were run by the nurses and health care assistants in conjunction with the doctors.

Healthcare assistants provided low cholesterol diet sheets for patients to help reduce cholesterol levels for those patients that needed it. They undertook 24 hour blood pressure monitoring and electrocardiogram (ECG) tests that record the electrical activity of the heart. They told us that they also ran health check sessions to prevent heart disease, kidney disease and stroke, and invitations were sent out to patients to attend.

All smokers aged 15 years and above were offered smoking cessation advice. Smoking cessation medicines were prescribed and patients also had the option to access other smoking cessation services.

The health visitors were closely involved in the healthcare of patients, particularly children. They attended the baby

Are services effective?

(for example, treatment is effective)

clinic at the Sundridge practice and Westerham village hall. Antenatal and postnatal care was carried out by both the doctors and midwives. A full range of family planning services was offered by the practice.

The practice offered an immunisation programme for babies and pre-school age children. There was a dedicated GP responsible for overseeing the primary care needs of children at a young disabled person's school. These children's physical health needs were regularly assessed and care was provided based on the results of those assessments.

Are services caring?

Summary of findings

The practice was caring. The practice carried out regular satisfaction surveys to capture patients' views. The patients we spoke with and the feedback cards we reviewed were very positive about the care patients received. Patients told us that staff were kind, caring and respectful throughout the episode of care that they had received.

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with 25 patients. Without exception patients were complimentary about the care they received and told us that the staff were helpful, knowledgeable and that they felt safe and well cared for.

There were arrangements in place to ensure patients received care in an environment which promoted privacy and dignity. There was a policy for privacy and dignity that was kept in the main reception. Consultation rooms were private and protected patients' privacy and dignity. We noted that the doors of the rooms were closed during consultations and that patient inside could not be overheard. We saw signs on the clinical room doors which read 'Do not enter examination in progress'. Clinical staff told us that when an examination was in progress, they would close the blinds and pull curtains around the examination couch in order to protect patient's privacy.

We spoke with staff about respecting patients' privacy and confidentiality. The nurse practitioner told us that all staff in the practice had to complete the on-line learning module for this topic. We saw there were posters in each clinical room with regards to requesting a chaperone during clinical examination. The nurse practitioner told us they routinely offered a chaperone to patients having intimate examinations.

Staff were able to give particular examples of how they ensured patients' dignity was maintained. One example given was that of a female patient whose culture and belief was that they should not be touched in intimate places. The member of clinical staff told us that they reassured the patient that they would not do anything that she did not feel comfortable with and managed her treatment based on discussion. Another example given was that of a patient who only spoke French. Staff told us they managed to communicate with the patient by sign language.

Involvement in decisions and consent

Staff we spoke with told us that before any invasive procedure was undertaken, they would inform the patient and would gain consent.

Staff told us they would not perform any procedure that people who lacked capacity did not understand. They told us if they were concerned that a patient did not have capacity to understand proposed care or treatment, they

Are services caring?

would discuss this concern with a GP. The said a 'Best Interest' meeting would be held with a multidisciplinary team and the GP, as the team would know the family. Staff told us that in the case of a patient who lacked the capacity to consent, an advocate or carer would be encouraged to accompany them for their appointment.

We saw that there was a practice register for patients with dementia. We found that the GPs had a very high awareness of dementia and carried out 'opportunistic' and 'at risk' screening for patients with dementia. All the clinicians were aware of the referral pathway for accessing the memory clinic offered by another provider.

Patients and those close to them were supported to receive emotional support from suitably trained staff if they needed it. Counsellors were available at the practice and patients were normally referred to them by the doctors. The practice also kept an up to date list of telephone numbers for counselling services and the crisis team.

Staff we spoke with told us that they had been involved in discussions about the Mental Capacity Act 2005 (MCA 2005). Receptionists were able to demonstrate their understanding of the MCA 2005. The practice staff responded to concerns involving patient safety. For example, we were told that one patient who regularly phoned the surgery had not been in contact for some time. A member of staff escalated this information to the local mental health team and action was taken. They identified that the patient had gone missing and was eventually found due to them raising the concern.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. There were mechanisms in place to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided and they were listened to and actions had been taken to make changes where practicable to do so.

Our findings

Responding to and meeting people's needs

The practice had a Patient Participation Group (PPG) who they worked with to address concerns from patients.

We saw from the last practice patient survey in January 2014, that approximately 50% of patients rated their satisfaction with the services provided as excellent and 40% as good. We saw that there was one concern raised by patients around the privacy in the reception area at the Sundridge practice. We were told that when consultations were undertaken in the nurses' room, conversations between medical staff and patients could be overheard in the waiting room. We saw that the practice had plans for the proposed changes to install a sound proof dividing wall between the nurses' room and the waiting room. There were also plans to change the current layout of the nurses' room, so that the desk would be on the far side of the room away from the door. This showed that the practice responded to patients' needs and concerns.

The practice provided home visits for those who were housebound or too ill to leave their home. There were district nurses attached to the practice who were available to give nursing care to patients in their homes.

The practice had a named GP who visited 26 patients on a weekly basis at a local residential home. Patients from the home underwent medical and medication reviews up to twice a year (when appropriate) depending on their conditions. Patients with dementia were invited for an annual review or when patients presented at the practice to see a GP for other complaints, reviews were done following the Quality and Outcomes Framework (QOF) template for dementia. Therefore, care and treatment was delivered in line with recognised best practice standards.

Patients requiring repeat prescriptions were able to do so either on line, in writing or put the repeat prescription in the post box in reception. The practice did not routinely take prescription requests over the telephone, however, they did for certain patients with known difficulties or if a patient was going to run out of medication imminently.The practice had arrangements with neighbouring pharmacies who operated a collection service on the patient's behalf.

Access to the service

The practice opened 8.00am to 6.00pm Monday to Friday. Urgent appointments were accommodated on the same

Are services responsive to people's needs?

(for example, to feedback?)

day, but not necessarily with a particular doctor. The practice offered extended hours during the evenings and early morning, each week at the Westerham site. This was primarily for patients who found it difficult to attend the practice at other times. The practice also provided a telephone consultation service.

Patients we spoke with complained there was a long wait for appointments if they wished to see their own doctor.

The manager and a receptionist told us that emergency appointments were available each day. Patients told us that most of the time they would ring for an appointment but when they needed them emergency appointments were often unavailable. Patients told us the practice's phone lines opened at 8.00 am but emergency appointments were often all taken by 8.10 am.

We found that the practice used a 'triage' system which was used to ensure patients were seen by the most appropriate GP or nurse for their needs. This meant that the receptionists, although they did not have a clinical background and could not diagnose patients, take details and information to pass to the GP so that a decision to either see or speak with the patient could be made.

Concerns and complaints

The practice had an effective complaints policy and procedure. We saw that if a patient needed help in pursuing their complaint there were contact details for the Kent NHS complaints advocacy service and the Parliamentary and Health Service Ombudsman. There were leaflets and posters in the patients' waiting room to guide patients on how to make a complaint and information regarding complaints was on the practice's website.

We looked at a sample of complaints received from January 2013 to December 2013. There was a system to investigate and resolve complaints. We saw that the practice was responsive to complaints and that lessons were learnt with actions taken. For example, we saw that customer services training had been provided for staff following a complaint about staff attitude.

Are services well-led?

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

Summary of findings

The practice was well led. Staff told us that they felt supported and that the practice was well-led. There were regular team meetings to ensure that information was cascaded to all staff team members. This included learning from incidents and any changes to practice across the organisation. There was a complaints policy and procedure in place as well as a process for escalating incidents to senior managers. All complaints and incidents were reviewed through the clinical meetings. Although there were a number of processes in place, there was little documented evidence and no overarching policy for the ratification of all the policies used at the practice.

Our findings

Leadership and culture

There were regular team meetings to ensure that information was cascaded to all staff team members. This included learning from incidents and any changes to practice across the organisation.

We spoke with a variety of staff across the two sites visited and we were told they felt there was an open culture and senior managers were supportive. Staff told us they felt part of a team and that they were provided with suitable opportunities for training and progression. Staff told us there was always someone senior available or who was contactable by phone if they needed advice.

Governance arrangements

The governance lead for the practice was a named GP. There was no clinical governance policy, however, we saw that there were processes in place and meetings were held to discuss governance issues. Although there were a number of processes in place, there was little documented evidence and no overarching policy for the ratification of all the policies used at the practice, however we saw that some had been discussed and agreed at the practice meetings.

We saw evidence that the practice operated a clinical audit system and addressed any areas which required improvement. The practice reviewed significant events and improvements were made when required. For example, at a clinical meeting, the practice discussed do not resuscitation forms with their palliative care nurse who felt it was very important for many patients and their families to have one of these in place where a patient might wish to die peacefully in their own home.

The nurse practitioner was the infection control lead and when we spoke with them they understood their role and responsibilities. A named GP was identified as the safeguarding lead.

Systems to monitor and improve quality and improvement

The practice nurse and dispensers attended practice clinical meetings at which prescribing and dispensing errors were discussed. There were meetings for staff to discuss significant events and to learn from these incidents as and when they arose. We saw that the practice had undertaken an analysis of five significant events in the last

Are services well-led?

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

12 months where learning points and actions had been recorded. For example, a query raised over safety of medicines prescribed for a pregnant lady and dispensing of incorrect medicines.

Patient experience and involvement

The practice had a Patient Participation Group (PPG) who they worked with to address concerns from patients.

The last practice patient survey, which was completed in January 2014, showed that approximately 50% of those who responded rated services provided by the practice as excellent and 40% as good. The chairperson told us that concerns raised by patients in the survey were being addressed. One example given was around the privacy in the reception area at the Sundridge practice. We were told that when consultations were undertaken in the nurses' room, conversations between medical staff and patients could often be overheard in the waiting room. We saw that the practice had plans to install a sound proof dividing wall between the nurses' room and the waiting room, and to change the current layout of the nurses' room.

Staff engagement and involvement

We saw evidence of regular staff meetings and meetings held with other providers. We spoke with a variety of staff across the two sites we visited. Staff told us they felt there was an open culture where they could raise concerns and senior managers were supportive.

Learning and improvement

The practice was designated as a 'training practice' where trainee doctors were offered placements to develop their knowledge, skills and clinical competencies. There were two GP trainees at the practice, however, they were on maternity leave at the time of our visit. We looked at four feedback forms from previous trainees who had been at the practice between 2009-2013. Their feedback indicated their experiences had been positive. Trainees felt supported and said practice staff were friendly and approachable. They had all received an induction at the beginning of their placement.

The practice manager told us that the practice actively encouraged staff development for the benefit of the practice and patients. We were told by some staff that they had recently been supported to undertake a national qualification for Knowledge and Skills in Primary Care (KaSPaC) in administration and supervising skills. A member of staff told us that after completing an KaSPaC they had recently been appointed as a healthcare assistant (HCA).

Identification and management of risk

The practice did not have a risk management or clinical governance policy in place. However, there were processes in place and meetings to discuss governance issues. There were also mechanisms in place for improving practice and the environment based on risk assessments. Relevant fire safety checks were completed and electrical testing was up to date. This ensured that the practice and equipment were safe and risks to staff, patients and premises were reduced.

Older people

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

Summary of findings

The practice proactively identified patients and their carers who may have needed on-going support. The practice provided visits for those who were housebound or too ill to visit the surgery. There were district nurses attached to the practice who were available to give nursing care to patients in their homes. The practice had a named GP who visited 26 patients on a weekly basis at a local residential home.

Our findings

The practice provided GP and district nurses visits for those who were housebound or too ill to visit the surgery. There were district nurses attached to the practice who were available to give nursing care to patients in their homes.

The practice had a named GP who visited 26 patients on a weekly basis at a local residential home. Patients from the home underwent medical and medication reviews up to twice a year (when appropriate) depending on their conditions. Patients with dementia were invited for an annual review or opportunistically.

Patients requiring repeat prescriptions were able to do so either on line, in writing or put the repeat prescription in the post box in reception. The practice did not routinely take prescription requests over the telephone, however, they did for certain patients with known difficulties or if a patient was going to run out of medication imminently. The practice had arrangements with neighbouring pharmacies who operated a collection service on the patient's behalf, this enabled patients obtain their medicines without having to leave their home.

People with long term conditions

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

Summary of findings

We saw that the practice provided diabetic, weight management and asthma clinics that were run by the nurses and health care assistants in conjunction with the doctors. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

Our findings

The practice provided diabetic, weight management and asthma clinics which were run by the nurses and health care assistants in conjunction with the doctors.

We spoke with the nurse practitioner, who was the lead clinician for patients with asthma and chronic obstructive pulmonary disease (COPD).

Each patient with asthma received a letter from the practice annually to arrange an asthma review with the nurse practitioner. The practice were aware that certain patient groups, such as those working during the surgery working time hours and young children who attended school may find it difficult to attend. Efforts had been made to respond to patients needs for example, telephone consultations for those who were not able to attend the surgery due to work restrictions, and invitations for review for school children during school holidays to improve access.

The 'Royal College of Physician's (RCP) guidance' was used to review patients with asthma. The lead clinician for asthma also performed spirometry and was aware of the National Institute of Health and Care Excellence (NICE) guidance in Asthma care.

We spoke with two healthcare assistants who told us that their role was to undertake blood tests to monitor the blood sugar levels of patients with diabetes and blood tests for patients who were taking Warfarin, a blood thinning medicine.

Mothers, babies, children and young people

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

Summary of findings

The health visitors were closely involved in the healthcare of patients, particularly children. They attended the baby clinic at the Sundridge practice and Westerham village hall. Antenatal and postnatal care was carried out by both the doctors and midwives. A full range of family planning services were offered by the practice.

The practice offered an immunisation programme for babies and pre-school age children. There was a dedicated GP responsible for overseeing the primary care needs of children at a young disabled person's school. These children's physical health needs were regularly assessed and care was provided based on the results of those assessments.

Our findings

The practice had a range of patient information leaflets in the waiting area. A practice booklet was also available either in paper form or electronically from the practice's website. Information included details of cervical screening clinics, family planning clinics, child health and immunisation.

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Working age people (and those recently retired)

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

Summary of findings

The practice offered extended hours during the evenings and early morning, each week at the Westerham site. This was primarily for patients who found it difficult to attend during working hours.

Medical examinations for special purposes, for example, life insurance, school entrance, elderly drivers, pre-employment, fitness to undertake sports and fitness to travel were undertaken at both surgeries. The practice nurses were available to offer medical advice regarding travel and to vaccinate where appropriate

All smokers aged 15 years and above were offered smoking cessation advice.

Our findings

The practice opened 8.00am to 6.00pm Monday to Friday. Urgent appointments were accommodated on the same day, but not necessarily with a particular doctor. The practice offered extended hours during the evenings and early morning, each week at the Westerham site. This was primarily for patients who found it difficult to attend the practice at other times. The practice also provided a telephone consultation service.

Patients requiring repeat prescriptions were able to do so either on line, in writing or put the repeat prescription in the post box in reception. The practice did not routinely take prescription requests over the telephone, however, they did for certain patients with known difficulties or if a patient was going to run out of medication imminently. The practice had arrangements with neighbouring pharmacies who operated a collection service on the patient's behalf.

The practice had a range of patient information leaflets in the waiting area. A practice booklet was also available either in paper form or electronically from the practice's website.

All smokers aged 15 years and above were offered smoking cessation advice. Smoking cessation medicines were being prescribed in the practice and patients also had the option to access other smoking cessation services.

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

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

Summary of findings

The practice told us it did not have specific groups of patients in vulnerable circumstances such as travellers, homeless people or asylum seekers. However, staff had access to interpreters and information in different languages. In addition, there was an agreed policy that the practice would use its own address for anyone that was homeless to ensure they were able to receive appropriate care and support. There was access to a loop for people who had a hearing impairment and, if required, they would contact a local service for signing.

Patients with learning disabilities (excluding children) were assessed by the nurse practitioner and an annual review was undertaken of their physical, psychological and social circumstances.

Our findings

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Patients with learning disabilities (excluding children) were assessed by the nurse practitioner and an annual review was undertaken of their physical, psychological and social circumstances.

People experiencing poor mental health

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

Summary of findings

There was a practice register for patients with dementia. We found that GPs had a high awareness of dementia and carried out 'opportunistic' and 'at risk' screening for patients with dementia. Patients with depression were seen within two weeks of their diagnosis and had regular follow ups thereafter.

Patients and those close to them were supported to receive emotional support from suitably trained staff if they needed it. Counsellors were available at the practice and patients were normally referred to them by the doctors. The practice also kept an up to date list of telephone numbers for counselling services and the crisis team.

Our findings

We were told that staff had received training in the Mental Capacity Act 2005 (MCA 2005) and training records we saw confirmed this. Staff we spoke with told us that they had been involved in discussions about the MCA 2005 and receptionists we spoke with demonstrated their understanding of this legislation.

There was a practice register for patients with dementia. We found that GPs had an awareness of dementia and carried out 'opportunistic' and 'at risk' screening for patients' with dementia. There was a referral pathway for patients who needed to be seen at the memory clinic and clinicians were aware of requirements related to this pathway.

There were arrangements in place to diagnose and review patients with mental health conditions, including referral pathways for patients who needed care or treatment which the practice was not able to provide. Counselling, talking therapies, anti-depressant medication or private referral were offered to patients with mild to moderate depression. Patients with severe depression had an urgent referral made to a psychiatry team for further management. We were told patients with depression who were appropriate to be managed in a community (GP) setting would have a follow up within two weeks of their diagnosis, then two to four weeks depending on their severity and response to their treatment. Anti-depressants were prescribed to individual patients if a risk assessment of the patient's need warranted it. Patients and those close to them were supported to receive emotional support from suitably trained staff if they needed it. Counsellors were available at the practice and patients were normally referred to them by the doctors. The practice also kept an up to date list of telephone numbers for counselling services and the crisis team.

Patients with learning disabilities (excluding children) were assessed by the nurse practitioner and an annual review was undertaken of their physical, psychological and social circumstances.