# Parkside Surgery

## Quality Report

Parkside
Cliffe Woods
Rochester
Kent
ME3 8HX
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Website: www.theparksmedicalpracticemedway.co.uk

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Parkside Surgery on 17 December 2014. During the inspection we spoke with patients, members of the patient participation group (PPG), interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing safe, responsive, effective, caring and well led services. It was good for providing services for older people, people with long-term conditions, for working age people (including those recently retired and students) and families, children and young people. people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example audit of inherited high cholesterol
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- 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
- The practice had a clear vision which had quality and safety as its top priority. High standards were

# Summary of findings

promoted and owned by all practice staff with evidence of team working across all roles. The practice contributed leadership and mentoring locally and nationally.

We saw one area of outstanding practice including:

- The practice had conducted audits that influenced health care locally and nationally.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

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

**Are services effective?**

Good

The practice is rated as good for providing effective services. There were systems to help ensure that all GPs and nurses were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. These guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to other similar practices. The practice was using innovative methods to improve patient outcomes and it linked with other local providers to share best practice. It had conducted audits that influenced care locally and nationally. There were processes for helping those in mental health crisis.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Patients' choices and preferences were valued and acted on. These included arranging for patients with learning disability to be seen in a sensitive manner; arranging for carers to be offered support within their own homes and careful management of multi-disciplinary team meetings.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local patient population, engaged with the NHS England Area Team and clinical

# Summary of findings

commissioning group (CCG) to secure service improvements where these had been identified as being required. It continued to provide enhanced services to vulnerable patients even after much of the funding to do so was withdrawn.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, which provided continuity of care, and urgent appointments were available the same day. There was a "sit and wait" service for any patient who had not been able to make an appointment. 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, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and others.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. This vision included being a part of the community the practice served. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

The practice contributed to the development of the clinical commissioning group (CCG) and provided training, mentorship and guidance to other providers locally and nationally.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were very good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of their older patients. The practice used a frailty index and other risk tools to identify older patients most at risk. Specific administrative staff were tasked with organising and managing multidisciplinary meetings designed to provided individualised care. Specific GPs were responsible for end of life care and dementia care. Communication with the out of hours service regarding the needs of older patients was well organised and effective.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients with more than one long-term condition were seen in extended appointments which considered their holistic care, as opposed to repeatedly attending different clinics. The practice had undertaken work to help identify patients with specific long-term conditions which were likely to have an impact nationally. Patients with long-term conditions had named GPs and a structured annual review to check that their health and medication needs were being met. NHS health checks conducted by the practice had resulted in long-term conditions being identified at an early stage.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency attendances. Immunisation rates were generally slightly higher than nationally for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age patient population, those recently retired and students had been identified and the practice had adjusted the services it offered to help ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for patients with a learning disability. It offered longer appointments for patients with a learning disability. Appointments for patients with a learning disability were arranged with consideration for the needs of the patients as well as their carers. The practice continued to provide enhanced services to all its patients with learning disability despite only being funded for less than half of them. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 98% of patients experiencing poor mental health had received an annual physical health check. The practice has a GP qualified in the care of patients with mental health problems. Patients were referred within the practice to this GP. The practice had built working relationships with local mental health services as well as access to advice and secondary care. There was a GP lead for patients with dementia.

Patients experiencing poor mental health were encouraged to attend with family members or carers to explain their problems and how these affected themselves and their family or carers. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for

# Summary of findings

patients with dementia. There was signposting to support services for patients experiencing poor mental health and dementia. Staff had received training on how to care for patients with mental health needs and dementia.

The practice had delivered training to GPs across the CCG aimed at improving the care and treatment for patients with mental health problems in the locality.

# Summary of findings

## What people who use the service say

We spoke with seven patients. We received 13 completed comment cards.

Patients we spoke with and comments cards we received indicated they were pleased with the quality of care they had received at Parkside Surgery. They all said it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment. Several patients commented that the new appointment system made it easier to see a GP, especially if urgent, though not always with the preferred GP.

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 256 survey forms were sent out and 115 were returned. The practice had good results from the survey, some results exceptionally so. For example in the section "accessing your services" the practice was above the average for the CCG. In the sections concerning the quality of the last GP or nurse appointment the practice was rated significantly better that the CCG average

Since this survey the practice had had a new telephone system installed and patients reported that this was an improvement, making it easier to get through to the practice. There had also been changes to the appointments system and an increase in the number of GP sessions available to patients.

## Outstanding practice

- The practice had conducted audits that influenced health care locally and nationally.

# Parkside Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Parkside Surgery

Parkside Surgery is a GP practice located in a part urban area and part rural area of Rochester, Kent and provides care for approximately 8,600 patients. The practice has somewhat less than the national average of patients over 65 years and over 75 years and only two thirds of the national average of patients over 85 years. It is not overall an area of high depravation though there are patches of high depravation within the practice boundaries.

There are six GP partners, three female and three male, as well as one male salaried GP. There are 35 GP sessions each week, one session being half a day. There are two female nurses providing 26 nurse sessions weekly and there are two female healthcare assistants. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is a training practice.

Services are delivered from the central surgery at;

Parkside

Cliffe Woods

Rochester Kent

ME3 8HX

There is a branch surgery at;

The Parks Medical Practice

Wainscott Surgery

Miller Way Wainscott

Rochester Kent

ME2 4LP

We did not visit the branch surgery

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care.

## Why we carried out this inspection

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

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

This provider had not been inspected before and that was why we included them.

# Detailed findings

## How we carried out this inspection

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

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

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 17 December 2014. During our visit we spoke with a range of staff including GP partners, nursing staff, receptionists and administrators. We spoke with patients who used the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, significant events or incidents and national patient safety alerts as well as comments and complaints received from patients of other providers. The staff we spoke with understood the policy relating to significant events and were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there had been an error in prescribing a medicine. Investigation showed this occurred partially because the prescriber was unfamiliar with changes to the electronic prescribing system. The individual had since received additional training.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. There was regular reporting of events which indicated an open approach to reporting incidents and there was evidence of learning from them.

### Learning and improvement from safety incidents

The practice had systems for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year . Staff used incident forms on the practice intranet and sent completed forms to the practice manager. The practice manager was responsible for managing the process of any investigation. Records of incidents that we looked at demonstrated they had been investigated in a comprehensive and timely manner.

The significant event log included details of any action plans to reduce risks and who was responsible for their implementation. There were regular practice meetings on Monday lunchtimes and significant events were a standing item on the agenda. Learning from these meetings had included items such as checking numbers on the “fax” machine and putting in pre dialled numbers to reduce the likelihood of mistakes. In another instance test results from a particular provider arrived at the practice late on a Friday evening. As the relevant GP was not there to assess them there was a delay, over the weekend, which led to distress to patients and the practice deemed this a significant event. This was investigated and discussed and a “buddy” system was introduced that helped ensure that sufficient GP cover was now available to reduce this risk of this incident happening again. Other learning encompassed discussions with district nurses and improved communications with pharmacists.

Where there had been errors that impacted on patients, they were provided with an explanation of what had happened and, where appropriate, a written apology. The records showed that patients appreciated the practice’s candour.

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

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that all the GPs were trained to the appropriate level (level 3). GPs had undertaken further training related to safeguarding such as courses on recognising and dealing with domestic abuse. There was a lead GP and a lead nurse for safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They knew who the leads were for safeguarding and to whom these should be reported. Staff had been trained to the appropriate level, level two for nurses and level one for others. There were notices and flow charts displayed within the practice to remind and inform staff about the processes to be followed in reporting a safeguarding. Staff were able to tell us about safeguarding incidents that had been reported and investigated in accordance with the protocols.

There was a system to highlight vulnerable patients on the practice’s electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans. The lead GP for safeguarding was aware of vulnerable children as well as adults in the practice and regularly liaised with other agencies such as the local authority and local social services.

There was a chaperone policy. There were posters about chaperoning displayed on the waiting room noticeboard and in consulting rooms. There were sufficient staff trained

to act as chaperones. Where a chaperone was used this was noted on the patient's record. Staff who were able to act as chaperones had a badge, in addition to their identity badge, stating that they were able to act as chaperones. This allowed patients to be re-assured that the staff were competent to act as chaperones and reduced the possibility of someone who was not qualified, being asked to act as a chaperone.

### Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure that medicines were kept at the required temperatures and which described the action to take in the event of a power failure. There had been a power failure which had affected the storage of the vaccines and medicines and staff had followed the correct policy.

There was a stock control process to help ensure that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The patterns of antibiotic, hypnotics as well as sedatives and anti-psychotic prescribing were within the range that would be expected for such a practice. The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions these had been signed by the staff concerned. There was evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

### Cleanliness and infection control

The premises including the treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with personal protective equipment (PPE) including a range of disposable gloves, aprons and coverings. Antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice. The fittings within the building were modern and compliant with recent guidance.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. Audits had been carried out and these had resulted in changes such as the scheduled collection and fixings of "sharps" bins, used to dispose contaminated sharps such as needles, and the storage of temperature sensitive medicines in the light of recent guidance. There were notices in the consulting and treatment rooms as to what action to take in the event of a needle stick injury.

An infection control policy and supporting procedures were available for staff to refer to, which helped enable them to plan and implement measures to control infection. For example, PPE was available to staff and staff were able to describe how they would use the equipment to comply with the practice's infection control policy such as the use of disposable couch coverings and the management of hazardous waste.

There were cleaning schedules and cleaning records were kept. Privacy curtains around the couches were disposable and had stickers indicating when they should be changed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

### Equipment

Staff told us they had sufficient equipment to help enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. An independent contractor carried out this work and maintenance logs and other records confirmed that the testing had been completed. All portable electrical equipment was routinely tested and there was a schedule to help ensure this was carried out when scheduled. The equipment we looked at had been tested and appeared in good working order.

### Staffing and recruitment

Records contained evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at staff files and saw that there was proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a policy that set out the standards for recruiting staff.

There was a rota system for all the different staffing groups to help ensure there were enough staff on duty. The rota system helped ensure that staff, including GPs, nurses and

# Are services safe?

administrative staff covered each other's annual leave. The practice monitored the need for changes to staffing regimes and had recently appointed a reception manager to support staff working in this area.

### Monitoring safety and responding to risk

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. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied and the door shut to prevent unauthorised access.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment and emergency medicines were available including access to medical oxygen. The practice did not have an automated external defibrillator. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency medicines we looked at were in date and checked regularly together with the emergency equipment.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The practice had two surgeries and much of the planning involved using the unaffected premises to reduce the impact of the event on the care to patients, although there were also detailed plans to use the local community hall if necessary. There were detailed plans of the action to be taken in the event of a winter crisis affecting patients such as widespread influenza or severe cold weather. The plans had details of important contacts such as maintenance companies and local authority officers.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Patients' calls were only screened by receptionists to help ensure that they did not need immediate referral to the emergency services. All patients who said they needed an appointment received one.

We talked with the GPs and nurses who said they completed assessments in accordance with NICE guidelines, this included the regular reviews of patient care and treatment as indicated by the guidance. Staff used other guidance, such as the Cardiff health questionnaire for patients with learning disability, when appropriate. All these guidelines were available to staff on the practice's computer system.

There was a weekly meeting of GPs and nurses each Monday lunchtime where new guidelines were disseminated, recent safety alerts cascaded and the practice's performance discussed. Staff also took the opportunity to talk about complex cases. All the staff we spoke with were open about asking for and providing colleagues with advice and support.

One GP had recently attended a training course for testing for human immunodeficiency virus (HIV). The training had been cascaded to other GPs and GPs were now testing for HIV when dealing with patients who presented with symptoms of acquired immunodeficiency syndrome (AIDS). There were GP leads for various specialist areas such as mental health, end of life care as well as learning disability and the practice nurses supported this work.

The available data showed that the practice's performance for prescribing, including antibiotics, hypnotic medicines and painkillers was comparable to other similar practices. The practice used clinically recognised risk stratification tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

There was regular audit and monitoring to help assure and improve outcomes for patients. There had been an audit into inherited high cholesterol. This audit had had five cycles of data collection. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to help ensure outcomes for patients had improved. The first audit cycle showed that the prevalence of the disease in the practice was 0.1% that is 8 diagnosed out of 8000. This was half the UK predicted rate for the disease, which itself is believed to be an under estimation. The cycles of audit were refined and by the fifth cycle the prevalence rate was 0.7%. As a result of the practice's work some 50 additional patients had been identified with a condition that confers a lifelong risk of premature coronary heart disease. Those patients were then able to decide on any treatment.

There was an audit of records to identify patients who might be at risk of coeliac disease. It was in its early stages and the aim was to identify patients who were displaying symptoms of the disease so as to determine who had been properly diagnosed and who might be offered further tests.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw audits regarding risk of falls in patients over 75 years, of the care plans of patients with learning disability to help ensure that their physical needs were met and audits looking for missed diagnoses across a range of conditions.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, there is a range of routine tests that guidelines suggest should be available to patients with diabetes. The practice scored highly in achieving this, with the

Good

# Are services effective?

(for example, treatment is effective)

percentages of patients receiving the tests being between 87% and 100%. These results placed the practice in the top fifth of practices in the country. This achievement was reflected in other areas of chronic disease management. The practice demonstrated that it was effective in diagnosing conditions and in helping patients to manage their conditions.

There was a protocol for repeat prescribing which followed national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. One of the GPs was the lead for end of life care. There were care plans for these patients and an alert on the electronic record stating "care plan priority" to informed staff to the importance the practice placed on care planning.

There were processes for helping those in mental health crisis. The practice has a GP qualified in the care of patients with mental health problems. Patients were referred within the practice to this GP. The practice could also refer to the crisis response service for acute issues. There was a GP advice line direct to a mental health consultant for issues such as medicines and assessment. There was a telephone contact to the local mental health team so that review of the patient could be arranged that day.

The practice used a "frailty index" to identify the degree of risk of severe declines in the health of older patients. The use of a frailty index tool is in line with recognised best practice. The index was used to identify patients who were offered an individual care plan. The care plan included areas such as the falls assessments and what to do in the event of a fall. Patients with a care plan were automatically offered longer appointments. There was a community matron, provided by the clinical commissioning group (CCG), to bring additional services to this patient group. All patients over 75 years had a named GP and were invited to receive an immunisation for shingles.

### Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. Records showed there was an overall training plan and mandatory training such as safeguarding, basic life support and infection prevention control had been completed by all staff. The areas of training that were considered to be most important for the safety of patients and staff had therefore been completed.

There was a good skill mix amongst the doctors with GPs having qualifications from the Royal College of Obstetricians and Gynaecologists, from the Faculty of Sexual & Reproductive Healthcare, in child health and in surgery. There was a GP with an interest in cancer and end of life care. This GP was the national lead GP advisor for a national cancer support charity and was also the clinical programme lead for end of life care for local CCG. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (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).

All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital (including discharge summaries), out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Results were received throughout the day and were frequently checked. Where there had been a breakdown in the system the practice had investigated and

Good

# Are services effective?

## (for example, treatment is effective)

had acted to reduce the risk of this happening again. The GPs who saw the documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

The practice was commissioned for the new enhanced service designed to prevent unplanned admission to hospital (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice received weekly data on hospital admission about their patients and reviewed this.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients. For example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented. There was a meeting between primary health care providers every eight weeks to discuss patients whose condition was cause for concern. It was attended by district nurses and practice nurses or GPs as appropriate and centred on the care of patients who were on the "care plan priority" list or those who were frail.

The practice GPs were involved with the local clinical commissioning group (CCG), a senior partner was the chief clinical officer and other partners had roles such as lead for mental health, end of life care and dementia.

The lead for mental health had delivered a mental health training programme for the GPs across the CCG. The practice had contributed to local and national initiatives. The practice was involved in development of cancer audit tool. It had worked with other providers, charitable organisations, academics and private industry to conduct the audit of high inherited cholesterol mentioned above. The audit had resulted in a number of national recommendations and an audit tool which is due to become available to GPs UK wide soon.

### Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software helped enable scanned paper communications, such as those from hospital, to be saved in the system for future reference. The organisation of care plans for end of life care was being unified across the various providers such as the practice, out-of-hours services, care homes and hospices so that staff would be looking at similar and familiar documents, information sharing would thus be improved.

There were plans to allow the out-of-hours service provider direct access to the practice's clinical system, to facilitate information exchange and make services safer for patients.

### Consent to care and treatment

Some GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice. We looked at an example of the treatment of a patient who did not have capacity to make the decisions needed. The patient was involved in the process, as far as was practicable. The patient, the patient's family and the health professionals made the decisions between them in the best interest of the patient. The process was properly documented with records in the patient's notes and alerts placed on the patient's electronic record to inform staff about the particular issues relating to that patient. There were notices in the consulting rooms showing best interest and MCA pathways to help GPs and nurses follow the correct procedures.

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded. Consent was specifically recorded for invasive procedures such as minor surgery. There were leaflets available to help patients understand the procedures, and consent was obtained in advance. The practice was a training practice and sometimes filmed consultations as an aid to training. The consent for this was obtained in advance, documented separately and retained with the recording. Recordings were only used for training purposes. Patients were asked at the end of consultation if they were willing for the recording to be used and if not the recording was deleted.

Patients with mental health problems and those with dementia were supported to make decisions through the use of care plans, in which they were involved. These plans showed the patient's preferences for treatment and decisions. Records showed that approximately 90% of patients in these two groups had care plans which had been reviewed within the last year.

Good

# Are services effective?

## (for example, treatment is effective)

### Health promotion and prevention

Staff told us all new patients were offered a health check. They were given a questionnaire and the nurse appointments included a new patient check. Those on repeat medications were referred to the appropriate specialist nurse appointment in the first instance and to a GP if necessary. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Staff told us of several instances where these checks had led to the early diagnosis of long term conditions.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. A specific GP was responsible for the care of those patients. They were all offered an annual physical health check.

There had been regular auditing, from 2010 to the time of the inspection, of the number of patients who smoked. Smoking cessation advice was provided by the healthcare assistants (HCA). The HCAs were able to refer smokers to a CCG wide smoking cessation programme.

The practice's performance for cervical smear showed that 87% of women who were eligible had taken up the test. This was significantly better than nationally and locally and placed the practice in the top fifth of practices in England.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG in child vaccinations, vaccinations for those over 65 years and for patients under 65 whose condition meant that they were at in increased risk if they caught influenza.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of patients undertaken by the practice. We spoke with patients and read the comment cards that patients had completed. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. A number of questions in the national patient survey cover the care in the practice. The responses to these questions were all at or above the national averages. The answers showed that patients felt GPs and nurse were good at listening to them, explaining test and results, giving them enough time to discuss their care. We saw that GPs collected their patients from the waiting room, this gave them the opportunity to talk with them and to assess aspects of their condition such as mobility.

Patients completed 13 comment cards to tell us what they thought about the practice. We also spoke with seven patients during our inspection. Both the comment cards and what the patients said were positive. This showed that patients felt they were satisfied with the care provided by the practice and said that their dignity and privacy were respected. General themes commented on were the practice's efficient and effective referrals to other services and the ability to provide appointments when patients felt they needed to see a GP or nurse on the day.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. Staff were careful to maintain patient confidentiality and, in the national patient survey, the proportion of respondents who stated that in the reception area other patients can't overhear was more than twice the national average. There were notices at reception about privacy and confidentiality directing patients to stand back from the reception desk until called forward. There was a private area where patients could talk to staff if they wished and there were notices telling patients about this facility. All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. All the consulting rooms had substantial doors and it was not possible to overhear what was being said in them. The rooms were, where necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

### Care planning and involvement in decisions about care and treatment

The patient survey information showed patients responded positively to questions about their involvement in planning and making decisions about their care as well as treatment and generally rated the practice well in these areas. Data from the national patient survey showed 85% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were slightly above average both locally and nationally.

Patients and their families were involved in decisions about end of life care. Do Not Attempt Resuscitation (DNACPR) decisions were made and documented, after discussions with the patients and families concerned. The local out-of-hours service held copies, with the patient's consent, of this in the form of a "my wishes" register. The register also contained other information such as the patients preferred place of dying.

Some patients with learning disabilities were seen at the practice on the day of the inspection. The practice brought in several patients from the same home at the same time, this allowed the carers to arrange staff rotas so that other people at the home where not left short of support. The reception staff were aware of these arrangements and were on hand to help if necessary. We spoke to carers who said that coming to the practice as a group provided patients with learning disability with mutual support.

The practice used the electronic care record to alert staff to patients with certain conditions. Where patients had a number of conditions staff tried to make a single, extended, appointment so that that individual's needs could be attended to in one visit. This avoided patients making repeated visit to separate clinics for each condition. There was addition nurse training and support so that nurses were able to maintain this approach.

The practice had access to translation services and there were notices in the reception areas informing patents this service was available.

The practice had a GP with a special interest in mental health who had been responsible for delivering mental

Good

# Are services caring?

health training to GPs within the clinical commissioning group (CCG). This GP was involved where there was a determination about a patient's ability, under the Mental Capacity Act, to decide on their treatment. Patients were encouraged to involve their family in their treatment plans. They were encouraged to bring someone with them to their consultation to help explain and discuss the issues.

### Patient/carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access services such as those related to specific disabilities. There were notices in the patient waiting room and patient website that directed patients to support groups and organisations for carers. There was a protocol for staff to follow to help identify carers. Patients we spoke with, some of whom were also carers, said that the practice was very supportive of carers. There were events for carers and a carers group within the practice. Patients told us the carers group had been helpful in directing patients to available sources of help including financial, emotional and physical assistance. Events included carers' afternoons where carers were invited to an informal afternoon gathering, there were talks from organisations and professionals involved in various specialisms.

There was a structured approach to caring for patients with new diagnoses of life changing conditions such as cancer. A specified administrator was informed who recorded the details in a register and set up a multidisciplinary meeting involving services such as district nurses and the hospice as well as the practice nurse dealing with the patient. The administrator took minutes of the meetings and ensured that actions that had been decided at the meeting were carried out by the relevant staff so there was care available for the most vulnerable patients. Meetings also considered patients' wishes, beliefs and social needs. This administrator also arranged for a carers charity to visit patients and their carers at home, to listen to their concerns such as those about respite care and finance, and talk through what support was available.

There was information displayed, privately, so that staff were aware when a family had suffered a bereavement. The notes of the deceased family and partner (if any) were updated so that staff were aware of the family's loss and could respond sympathetically.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems to maintain the level of service provided. The needs of the practice patient population were understood and there were systems to address identified needs in the way services were delivered.

The practice was engaged with the local clinical commissioning group (CCG) and several GPs in the practice had roles within the CCG. The practice was working with the CCG in carrying out a review into the appointments system. There had been an assessment of how effectively the appointments system had been working. This had been completed during the autumn of 2014. As well as analysis of the use of appointments, patients had been asked their views directly, in the form of questionnaires, and the patient participation group (PPG) had been consulted. Action taken as a result of the review included that some appointment slots had been changed from pre-bookable to seen on the day and patients with 30 minute or more appointments were reminded the day before of their appointment. This was to reduce the number of patients who did not attend their appointments. There was further work planned to check how well the measures were working.

The practice had an active PPG which was called the care and concern group. We spoke with five members of the group who reported that the practice was very open to suggestions. The PPG had asked the practice if it was possible to have a Saturday morning clinic and this had been introduced. The group had also been useful in educating patients. For example, some complaints about the service related to the local pharmacies as opposed to the practice and the PPG had helped patients to understand the distinction between the two.

There were posters on display in the waiting area showing how the practice had responded called "you said … we did" notices.

### Tackling inequity and promoting equality

Patients with disabilities could access the practice. There was a ramp leading to the front door so that patients in wheel chairs could use it. The waiting area accommodated wheelchair users. There were toilets for the use of disabled patients and baby changing facilities.

There was a register of patients who had illnesses which made them particularly vulnerable. For example, those with learning disability or dementia. When staff accessed the notes of such patients a message was displayed on the computer screen to inform the staff member of the diagnosis. Staff were then able to manage their interaction with that person taking into account any difficulties that the patient might have, such as difficulties in communication, memory or understanding. Reception staff routinely called patients who had memory problems to remind them of their appointments.

### Access to the service

Primary medical services were provided Monday to Friday between the hours of 8.15am and 6pm. The practice closed at lunchtime between 1pm and 2.30pm. There was half day closing (1pm) on Wednesdays at Cliffe Woods although the branch surgery remained open. In addition Cliffe Woods was open between 8.45am and 1pm on Saturdays. Patients were allocated a GP and their appointments were with this GP unless urgent or the GP was unavailable for some time, such as on leave. Receptionists did not triage cases and all patients who felt they needed an appointment received one. There were pre-bookable appointments, up to six weeks in advance, and appointments available on the day. The practice operated a "sit and wait" service. Any patient attending the practice who had not been able to make an appointment could wait to see a GP, these patients were seen at the end of each session, morning or afternoon, and a specific GP was allocated to complete this. There were telephone consultations available, on the day, for patients where this was appropriate.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits as well as how to book appointments through the website. There were also arrangements to help ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Vulnerable patients were seen where it was easiest for them. For example, elderly patients were often seen at the Wainscott surgery because of better public transport links there.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Longer appointments were available for patients who needed them including those with long-term conditions. There was a range of standard longer appointments. For example, patients with learning disabilities or dementia received 45 minute appointments. The practice had signed up to an enhanced service designed to encourage practices to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which includes producing a health action plan. This is a funded service. The practice continued to provide this service to all the identified patients despite the fact that, for technical reasons, it was unclear as to whether all the patients would be funded.

Other patients, such as those with mental health problems could ask for longer appointments. We heard reception staff booking these appointments and they accommodated patients' needs were at all possible. Patients who had a care plan had priority in the allocation of appointments and the computer system alerted reception staff to these patients when appointments were made.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the day of contacting the practice. For example, one patient commented that they had telephoned for an appointment at 3.30pm and had received an appointment at 4.10pm. Another patient called at 10.10am and had an appointment for 11am.

The practice's extended opening hours on Saturday mornings were particularly useful to patients with work commitments and two comment cards mentioned this.

### Listening and learning from concerns and complaints

There was a complaints policy which included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system; there were leaflets, notices and material on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However, they felt that if they had to make a complaint they would be listened to and the matter acted upon.

We looked at the complaints log. There was evidence of how the complaints had been handled and how the patients had been informed about the outcome. There had been learning from complaints and the complaints log showed the dates when various complaints had been discussed by the partners in the practice. The minutes of staff meetings also reflected learning from complaints. For example, the investigation of one complaint showed that there had been a breakdown in communication between the practice and a community service. As a result more certain and accountable methods of communication had been established between them.

The practice reviewed complaints annually to detect themes or trends but no particular themes had been identified.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The staff we spoke with told us they felt well led and described a practice that was open and transparent. Staff consistently said they understood what the practice stood for. For example, trying to ensure that patients saw their own (preferred) GP whenever possible, being responsive to the patients' needs and putting care at the centre of their activity. The vision encompassed being part of the community and the practice was involved in local fetes, school activity, fund raising and local support groups. There were weekly walks, coordinated with local organisations and leaving from the practice, that promoted healthy living. All the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to them.

### Governance arrangements

Clinical governance was covered in a range of activity. There were policies and procedures that guided staff and these were available to them on the desktop on any computer within the practice. We looked at some of these including recruitment, chaperoning, safeguarding, bereavement and complaints. There was evidence that staff had read the policies. The policies we looked at were in date and had dates assigned for their review.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GPs with responsibility for safeguarding and mental health. The staff we spoke with were clear about their own roles and responsibilities. Staff told us that the GPs had different areas of responsibility and they knew who to go to in the practice with any concerns. Partners were approachable. Staff felt valued and well supported.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with or better than national standards. QOF data was regularly discussed at team meetings and there were plans to maintain and improve outcomes. There were meetings where the minutes showed that the practice benchmarked itself against other practices locally and nationally. The practice had found that the referral rates for dermatology were higher than expected. One of GPs attended a dermatology course and cascaded learning to other GPs. Referral rates for dermatology were then lowered, this had been scrutinised and the level of referral and reasons for referral were under review.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action was needed. The practice showed us clinical audits that had been undertaken in the last year. These included audits of coeliac disease, chronic kidney disease (CKD), learning disability, inherited high cholesterol and cervical smears. All of the audits had resulted in improvements to patient care. Some audits such as that of coeliac disease were in their early stages. Others such as CKD, inherited high cholesterol and cervical smears had had repeated cycles to measure the progress that had been made.

The practice had arrangements for identifying, recording and managing risks. These included fire, flood and damage to the building. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented. For example, there was a fire risk assessment which showed the various actions taken to mitigate the risks and staff had received fire safety training.

There were partners meetings every week and governance was discussed at them. For example, staffing issues were discussed, including the impact of long term staff sickness on the individual, the team and practice performance. The practice had taken steps to reduce the risks to all concerned. For example, by obtaining occupational health advice.

### Leadership, openness and transparency

Records demonstrated that team meetings were held regularly. For example, meetings of the reception staff showed that staff rotas, home visits, overtime and complaints had been discussed; meetings of nurses showed that care plans, influenza vaccinations, QOF and high risk patients were discussed. It was clear that there was an open culture within the practice and staff had the opportunity and were happy to raise issues at team meetings. The partners held strategy meetings, usually on a Saturday out of practice hours, where the future direction of the practice was discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies.

# Are services well-led?

Good

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

For example, disciplinary procedures, induction policy, and recruitment, intended to support staff. There was a handbook available to all staff, which included sections on equality as well as harassment and bullying at work. The practice had a whistleblowing policy. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through a variety of means, including complaints, patients' surveys, the practice patient participation group (PPG) and suggestion boxes in the waiting rooms. There was an action plan resulting from this feedback. About a fifth of patients had found it difficult to get through on the telephone and, as a result, the practice had had a new telephone system installed.

The practice was also responsive to staff suggestions. Healthcare assistants (HCA) had suggested a new "pill check" protocol. The lead GP for mentoring nurses and HCAs had met with them and a new protocol had been developed which HCAs said had made their practice safer.

The practice had an active patient participation group (PPG). The PPG acknowledged that it was not as representative of the various patient population groups as it wished to be. It had canvassed patients and used events such as the carers' afternoons and community fetes to try and generate interest. However, in a recent poll carried out by the PPG 94% of respondents said that they were not interested in joining the group.

### Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Records showed that regular appraisals had taken place which included a personal development plan. Staff were very positive about the practice's commitment to staff development. Some staff we spoke with had joined as administrators and had gone on to be HCAs. Other staff spoke of the additional responsibilities that the practice had trained them to undertake. This was also true of several of the GPs who had come to the practice as registrars (trainee GPs) and had come back to serve at the practice following the completion of their training. There was a very low turnover of staff.

GPs provided training within and outside the practice. GPs had given tutorials within the practice on mental health and end of life care. GPs were involved in advising and training at CCG level and nationally. The practice was part of a pilot scheme, run with a local university, to provide training for new nurses at a community level. The traditional route into nursing was training at a hospital and moving to community settings later. This pilot, by its training approach, hoped to train nurses as "practice nurses" and thereby go some way to alleviating the shortage of practice nurses.

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 the 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.