

College Health Ltd Boots

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at College Health Boots on 12 November 2014. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice namely:

Summary of findings

- The practice had collaborated with a local charity support and promote the health of people who were homeless or living in temporary accommodation

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

Importantly the provider should

- Have an overall training plan which identifies staff mandatory training requirements
- Ensure that all staff receive mandatory training and that comprehensive training records are maintained

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

Good



Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely as were local care pathways. Patients' needs were assessed and care was planned and delivered in line with current best practice. This included assessment of capacity and the promotion of good health. Not all staff had received training appropriate to their roles. However further training needs had been identified and training courses were planned. All the staff had received appraisals and said they were useful. Multidisciplinary working was evidenced as was working with the local authority, local services and charities.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. Patients reported good access to the practice and urgent appointments were available on the day. The practice had modern spacious facilities and was well equipped. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints. The practice had responded to suggestions raised by the patient participation group.

Good



Summary of findings

Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff understood the vision and their responsibilities. There was a transparent leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity there were regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received induction, regular performance reviews and attended staff meetings and training events.

Good



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 is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people. It had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those who needed them.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. There were emergency processes for patients in this group who had a sudden deterioration in health. When needed, longer appointments and home visits were available. There were structured annual reviews to check their health and medicines' needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the population group of families, children and young people. There were systems for identifying and following-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 (A&E) attendances. Patients told us, and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There were emergency processes for children and pregnant women who had a sudden deterioration in health.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities. The practice had named GPs or nurses for some of the most vulnerable of these patients. The practice had collaborated with a local charity support and promote the health of people who were homeless or living in temporary accommodation.

Outstanding



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with the community psychiatric nurses and psychiatrists to manage the treatment of patients experiencing poor mental health including those with dementia. The practice had reviewed the A&E attendance of patients experiencing poor mental health. The practice had advance care planning for patients with dementia.

Good



Summary of findings

What people who use the service say

We spoke with 11 patients. We received 9 completed comment cards.

All the patients we spoke with or who completed the comment cards were pleased with the quality of the care they had received. Most 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 whilst there was continuity in the reception and nursing staff this was less so in respect of the GPs. Some commented that having to make an appointment on the day, as opposed to booking one in advance, could be an inconvenience. However most patients appreciated that this was mainly because so many patients failed to attend for the appointments they had made.

There was a survey of the practice carried out on behalf of the NHS twice a year. In this survey the practice results were compared with those of other practices. A total of 444 survey forms were sent out and 85 returned. The main results from that survey were:

What the practice did best

- Nurses were good at listening to patients, explaining tests and involving them in care planning.
- Patients satisfied with the practice's opening hours.

The practice could improve

- How GPs gave patients enough time, listened to them, explained tests and involved them in care.
- Patients' ability to see or speak with a preferred GP.

This was consistent with the comments about continuity of GPs made by the patients on their comment cards. This was linked to the use of locums, which the practice has addressed by using only one source of locums. College Health was also in the process of recruiting a GP specifically to work at this practice.

Areas for improvement

Action the service **SHOULD** take to improve

The provider should:

- Have an overall training plan which identifies staff mandatory training requirements
- Ensure that all staff receive mandatory training and that comprehensive training records are maintained.

Outstanding practice

- The practice had collaborated with a local charity support and promote the health of people who were homeless or living in temporary accommodation

College Health Ltd Boots

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to College Health Ltd Boots

College Health Boots is located within a pharmacy, in a shopping precinct, in Chatham town centre. The practice is run by College Health Limited, a private limited company. The directors of College Health Ltd are all GPs and supervise the services at College Health Boots. There is parking nearby. The surgery has seven consulting rooms.

The practice has an alternative provider medical services contract with NHS England for delivering primary care services to local communities. The practice has a “sister” practice about two miles away on the edge of the town. This is also operated by College Health Ltd and the lists of the two practices are combined. Patients on either practice’s list can attend either surgery. Staff work at both sites and the computer systems for the sites are linked. There are male and female locum and salaried GPs. There is a female practice nurse. Across both sites the practice provides between 25 and 30 GP sessions and 26 nurse sessions, which includes 10 sessions by an advanced nurse practitioner, each week. An advanced nurse practitioner is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice. The practice is a training practice although there were no trainees working at the practice at the time.

The practice is situated in a densely populated urban area and has a registered patient population of approximately 5,500 located within the town. The practice has more patients in the younger age groups than the national average. For example the practice has about 1200 patients under 18 years. There is a considerable student population. The number of patients recognised as suffering deprivation is the same as the local average but higher than the national average. The number of patients with long term medical conditions is more than the CCG average and more than the national average. There is a higher than average prevalence of long term conditions within all the age groups compared with national figures.

Services are delivered from

College Health,
30-34 Pentagon Centre,
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The practice has opted out of providing out-of-hours services to their own patients. Information is available to patients about how to contact the local Out of Hours Services.

Why we carried out this inspection

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

We carried out an inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our

Detailed findings

regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we held 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.

We placed comment cards in the surgery reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried

out an announced visit on 4 November 2014. During our visit we spoke with a range of staff including; GPs, the practice nurse, 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 risk and improve quality regarding patient safety. For example they considered reported incidents and accidents, national patient safety alerts as well as comments and complaints. This was a small practice and staff we spoke with felt confident that they could raise any safety issues. We looked at a recent significant event report where a travel vaccination had been given in error. It had been investigated. The reasons for the error had been identified and the GPs and nurses discussed the incident. The patient had been informed of the incident and the outcome. The changes resulting from the learning from the incident included using a system of colour coding for certain stock which was approaching its expiry date.

We reviewed safety records since May 2012. This showed the practice had managed incidents consistently and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. An incident book was used and the entries discussed with staff. Any individual could report a significant event. We looked at one event where notes had been scanned and attached to the wrong patient file. This involved two patients with the same name. The mistake was picked up because the work was checked. It was investigated and discussed at a weekly meeting. All staff were reminded to ensure that they checked patients' date of birth as well as their name. We looked at an incident where a two week cancer referral to a hospital had not been processed correctly. It was investigated and a breakdown in communication between the hospital and the practice identified. The practice now retained copies of faxes sent to the hospital, as proof of transmission, and improvements had been made to the system for checking of referrals.

We saw there was a process for dealing with safety alerts. These were received by the practice manager and, if relevant, were disseminated to the staff. We saw that staff were aware of alerts for example those concerning individuals who posed a risk to staff at the practice.

Reliable safety systems and processes including safeguarding

Patients said that they felt safe at the practice. The practice offered a chaperone option where a member of staff was available to accompany patients during examinations at their request (or at the instigation of the GP or nurse involved). We saw notices in the waiting area and in consultation rooms informing patients about chaperones.

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw there was a system where children and families at risk were monitored. The system also linked children and young people who had different surnames but lived in the same household. The details were recorded on the patient's electronic record so that when staff accessed the record they were immediately notified about the patient or family. The notification was coded so that it was apparent only to staff. The practice used specialist tools, such as the Sussex risk tool, to identify individual patients whose life style might place them at particular risk of admission to hospital.

The practice maintained a list of vulnerable adults and all their attendances at the local emergency department (A&E) so that they could monitor and contact those who regularly attended A&E. All A&E attendances were recorded on the front page of patient's electronic notes, in order that GPs and nurses could discuss with them why they had attended A&E as opposed to coming to the surgery. This was to increase the patients' understanding of the range of support available at the practice. The practice had found that for some vulnerable patients compliance with medicines and keeping appointments was a problem. They had a named GP or nurse for some of these patients in order to improve continuity of treatment.

We saw that the safeguarding vulnerable adults and children policies were up to date. There were also other documents readily available to staff that contained protocols for them to follow in order to recognise potential abuse and report it to the relevant safeguarding bodies. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. There was a lead GP for safeguarding children who had completed training to the required standard (level 3). Both the practice

Are services safe?

nurses had completed safeguarding children training to the required standard (level 2). We were told that other staff had completed safeguarding vulnerable children training but the practice could produce no evidence of this.

Medicines management

We checked medicines stored in the treatment rooms and the medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. The medicine refrigerators were not “hard wired” into the electrical system and there had been an incident where the refrigerator had been turned off.

Action had been taken to address this and staff were now aware of the risks and had taken steps to prevent a recurrence. The refrigerator automatically recorded the maximum and minimum temperatures and there was an audible alarm to notify staff if the temperature had gone outside of these parameters. There was written guidance, nearby, on the action to be taken if the safety parameters were breached.

Where the practice treated patients on substance misuse regimes the patients could only collect a limited amount of the medicine, usually sufficient for a single day. The patients signed to evidence that they had collected the prescription so that disputes about whether they had received their medicines were minimised.

Vaccines were administered by the nurse using directions that had been produced in line with legal requirements and national guidance. The nurse who administered the vaccines had been trained and their qualification had been renewed for the current year. The nurse was qualified as an independent prescriber.

Repeat prescriptions were handed into the practice or received electronically. They were not accepted over the telephone. The repeat prescriptions were checked by staff and were always checked by a GP before issue. If medicine reviews were indicated before a repeat prescription patients were notified. In any cases of doubt staff referred the matter to the GP.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness.

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. We saw that antibacterial gel was available in the reception area for people to use 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 the latest guidance. For example the floors were covered with a single sheet of material which continued part way up the wall. Taps were elbow operated and sinks did not have overflows. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company. There were cleaning schedules in place and we saw there was a supply of approved cleaning products. Sharps containers were date labelled and were not over-filled.

There was an infection control policy for staff to refer to, which enabled them to plan and implement measures to control infection. Staff were able to describe how they complied with the policy by renewing any disposable covers between examinations of patients and checking privacy curtain's to ensure they were changed when they reached the date marked for their replacement or immediately if soiled.

Staff we spoke with said that they had received training in infection prevention control. They had a sound knowledge of the principles of infection control. They were able to demonstrate correct hand washing techniques and the correct use of personal protective equipment. However the practice was not able to show which staff had received training in this area and when because records were incomplete.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and the equipment we saw had been tested. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

Personnel records we looked at contained evidence that appropriate checks had been undertaken prior to

Are services safe?

employment, for example, references and criminal records checks via the Disclosure and Barring Service (DBS) checks. However for some staff there was no proof of identity such as a copy of a passport or driving licence on file. There were records to show that the professional registration checks for all GPs and nurses with the Nursing Midwifery Council (NMC) or the General Medical Council (GMC) had been completed. The practice had a recruitment policy that set out the standards it followed when recruiting staff.

The practice comprised a small staff team and the manager ensured that only one member of staff was on leave at any one time. The staff covered for each other's absences. There was a second practice run by College Health nearby and practice staff could move from one site to another when the need arose. The practice was aware that patients considered that there was a high turnover of GPs. The practice employed locum GPs and only used one locum agency so that there was more continuity of GPs. The practice was also in the process of selecting a GP to work solely at this practice.

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. 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 was kept locked to prevent unauthorised access.

We saw that any risks were discussed at regular staff meetings and within team meetings. For example, we saw

that a back log in dealing with external post had been identified and the staff had explored the most effective means of reducing this and avoiding a reoccurrence once the back log had been cleared.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Emergency equipment was available including oxygen and two automated external defibrillators (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. It was checked by a named member of staff and there was a backup system if the named person was absent for any reason.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We checked these medicines and they were all within their expiry date.

There was a comprehensive business continuity plan. It covered areas such as loss of services, loss of energy and reverting to paper. There were two practices run by College Health in close proximity. The continuity plan encompassed moving between sites so that services could be maintained. Policies and protocols were being streamlined across the business with compatible ways of working to allow staff to switch efficiently between sites if the need arose.

There was evidence that the GPs and nurses had completed basic life support training. We were told that some administrative staff had completed this training but the practice could not produce comprehensive evidence of this.

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. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and care pathways from local commissioners. We saw that GPs and nurses signed copies of NICE as an acknowledgement that they had read them. The practice had completed a quality improvement assessment for the local clinical commissioning group that demonstrated how they implemented some of the care pathways.

There were nurses, specially trained, in clinical areas such as diabetes, heart disease and asthma as well as nurses trained in diagnostic and consultation skills. There was a clinical meeting each week, GPs and nurses were open in their discussions and provided supportive and, where appropriate, critical feedback to improve services for patients.

The medicines management team from the local CCG has complimented this practice on their performance for prescribing generally and had had praised the quality of the audits that the practice had conducted.

The GPs and nurses considered the local and national guidance. We saw from meeting minutes that the referrals were discussed and each one considered in the light of any guidance before the referral was confirmed. This also allowed those at the meeting to consider whether the referral was to the best local service for that condition.

We saw no evidence of discrimination when making care and treatment decisions. There was a referral meeting each week which scrutinised all the non-urgent referrals to secondary care. From the minutes we saw that patients were referred on the basis of need and suitability. Age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

All the staff in the practice had roles in monitoring and improving patient care. The roles included managing and

scheduling clinical and medicines' reviews and monitoring child protection and significant events. The information collected was used to help determine what audits the practice would conduct.

We looked at an audit of the use of particular NICE guidance. All patients presenting with Respiratory Tract Infections should be assessed using the Centor criteria (NICE 2008). The Centor criteria are a set of measures which may be used to identify the likelihood of a bacterial infection in adult patients complaining of a sore throat. The importance of determining whether the sore throat is caused by a virus or a bacterium is to reduce the over use of anti-antibiotics. The audit identified that the criteria were not being used as frequently as the practice had assumed or wanted. The results were discussed at a practice meeting where GPs, nurses, practice manager and some administrative staff were present. The consensus was that there was room for improvement and that staff would implement three specific changes to their clinical practice. The audit was repeated two months later and a marked improvement recorded.

The practice reviewed patients who attended the local emergency department (A&E). They identified problems with comparing their data to data from surrounding practices because of difficulties with local recording systems. The practice managed to partially resolve the issues. They examined the attendance of older patients and those with long term conditions. They had developed personal care plans as well identifying a named GP or nurse to manage these patients' care so as to reduce the likelihood of their attending A&E. The practice reviewed the records of all children under 15 years old who attended A&E with a view to providing additional care should there be any underlying problems. They found that most of the attendances were related to one off events such as sprains and head injuries and that there were no patients where additional help was identified.

Patients with long term conditions were provided with additional guidance. For example asthmatic and chronic obstructive pulmonary disease (COPD) sufferers were given clear guidance to help them identify when they should seek urgent and immediate care, when they needed to make an on the day appointment at the surgery or request a phone call from the respiratory nurses. Some patients with long term conditions were provided with anticipatory medicines. This allowed the patient to call the surgery if

Are services effective?

(for example, treatment is effective)

they were unwell for advice on whether to start using that medicine. They were advised, if they were unwell when the surgery was closed, to start the medicines and call the practice as soon as possible so the practice could schedule a review to determine the effectiveness of the medicines and assess the need to issue more.

There were meetings with other local practices so that College Health could benchmark their work against that of others. We looked at the minutes of one such meeting. It compared the practice's mental health patients' admissions with those of other practices. The review identified a number of issues common to practices in the Medway area. These focussed on problems of access to secondary mental health care. The review identified a number of actions that the practices could take across the Medway area. Some that College Health had already actioned were individual GPs or nurses allocated to mental health patients and longer appointment times for complex mental health patients.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. Comparison of QOF data in cervical screening identified that action was needed to bring the practice back up to national standards. The nurses meeting notes showed that nurse were addressing this by better monitoring of follow up processes to ensure that they had been completed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records. There was no overall training plan. The practice had not identified what training it regarded as essential and how often staff needed to undertake it. There was evidence that mandatory training such as safeguarding and basic life support had been completed by most staff and we were told that other staff had received some this training. Staff told us of the training that they had had in areas such as infection prevention control and information governance. Staff were able to tell us what they had learned from the training. However the practice could not produce adequate records of staff training.

Revalidation is the process by which doctors demonstrate they are up to date and fit to practise. One GP had been revalidated for 5 years and the other was due for revalidation. The practice maintained a record which

showed that all the GPs were up to date with their yearly continuing professional development requirements. A senior GP and director of College Health held regular clinical supervision meetings with GPs working at the practice. The meeting covered areas such as following clinical guidelines and ensuring induction was satisfactorily completed.

Nurses had undertaken a wide range of clinical training. There were nurses trained as independent prescribers and nurse practitioners (this is an advanced practice registered nurse who has completed advanced coursework and clinical education beyond that required of the generalist registered nurse). Nurses had undertaken a variety of courses including minor injuries, diabetes and asthma. One nurse was about to start an insulin initiation course. This would allow the practice to treat patients with diabetes in a more efficient and effective manner. There was a nurse with a diploma in management of COPD.

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. In addition there was a six monthly review to see how staff were progressing against their objectives. The records of appraisals, including action plans and follow up, were clear on all the files we looked at.

The practice used the apprentice scheme to recruit some new staff. We saw examples of staff who had been recruited through the scheme and who had developed into key administrators with a transparent commitment to the practice and its values.

Working with colleagues and other services

There were specific meetings with other health and social care providers. These meetings involved various professionals from outside and inside the practice, for example, district nurses, social services, GPs and other specialists. The GP safeguarding lead met with the local authority child protection and social services leads. The practice nurses met with the local hospice and other end of life care professionals. These meetings considered the treatment of patients receiving palliative care and involved a careful consideration of a patient's conditions, which included spiritual, where appropriate, as well as physical

Are services effective?

(for example, treatment is effective)

matters. The mental health team for the area came to the practice to discuss specific patients' needs, particularly those whose condition might be moving towards 'crisis' to ensure that their needs were met.

The practice worked with others in the area, for example patients were referred to other practices for treatments such as minor surgery. GPs and nurses worked with the home care team and the palliative care team from the clinical commissioning group, and with the local hospice and Macmillan nurses to provide end of life care.

We looked at a case study concerning the treatment of a mental health patient. It showed coordinated working between the GPs, the community psychiatric nurse and the psychiatrist, as a result of the cooperation the patient, who had regularly attended A&E in crisis, had not been to A&E during the previous 12 months.

Blood results, x-ray results, letters from the local hospital including discharge summaries and information from out of hours providers were received through a variety means, including electronic and traditional post. Blood test results that were markedly outside the normal parameters or which were deemed urgent were faxed to the practice and brought to the attention of the GP as soon as there was an opportunity. Other blood test results were routinely received electronically during the course of the day.

Information sharing

The practice had systems to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Information from the out of hours service (OOH) was received by fax or by e-mail and again was scanned into patients' notes. The practice used fax or e-mail to alert the OOH services of the details of patients receiving end of life care.

Consent to care and treatment

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. Staff we spoke with understood the consent and decision-making requirements of legislation and guidance.

Some GPs had received training in the Mental Capacity Act 2005 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 the attention of a GP. The staff had access to a mental capacity act "toolkit" on their computer system. This led them through the kinds of situations they were mostly likely to encounter in primary care. We saw an example where the practice had reviewed the mental capacity of an individual where concerns about treatment had arisen. The review found that the patient had had the capacity to decide on their treatment but chose not to access the treatment that was recommended.

Health promotion and prevention

All new patients were invited for health checks and there was an assessment to identify any 'at risk patients' such as children in need, looked after children or those on the child protection register. Any new patients who were carers or patients with complex needs were identified through this process. Where the assessment indicated it, for example those on repeat medicines or with chronic illnesses a referral was made to the appropriate specialist clinic in the first instance and to a GP if necessary. There were instructions on registration for new patients in a range of commonly spoken languages.

There was a range of leaflets available in the reception area. The practice website provided access to information in languages other than English. The practice website had a number of useful links and was easy to navigate. There was a page on long term conditions including mental health, cancer and asthma. There was a page on "your health" and this included links to topics such as child health, female and male health, sexual health and healthy living. Staff at the practice spoke a number of languages, these included some common eastern European languages as well as Gujarati and Urdu.

The practice had also identified 1171 patients over the age of 15 who were smokers and had offered smoking cessation clinics to 91% of these patients. This compared well with the rest of England where only about 83% received such an offer. The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. There were follow up mechanisms in place for those who did not attend. For example when children did not attend for vaccination, a follow up letter was sent. If they still did not attend a

Are services effective?

(for example, treatment is effective)

second letter was sent and on the third non-attendance a letter was sent telling the family that it might be necessary to discuss the non-attendance with the local safeguarding authority. The practice had found that this was effective in encouraging families to attend.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. The reception area was quiet at the time of the inspection and it was easy for staff to maintain confidentiality. There was a red line marked on the floor in front of the reception desk and a sign asking patients to stay behind the line until they were called, this helped to keep patient information confidential during busy times. There was a private area where patients could talk to staff if they wished and there were notices telling patients about this facility.

All the patients we spoke with told us that they felt the staff at the practice treated them with respect, were polite and considered their privacy and dignity at all times. This was reflected in the comment cards that patients completed. 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, if necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was appropriate.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff had had communication training in a "dealing with difficult patients" workshop. This was organised by a local NHS training provider. It was to give staff the confidence and communication skills to develop their own styles of interaction with difficult patients. The staff said that they were strongly supported by the practice in dealing with difficult or abusive patients. We saw from meeting minutes that the practice took action against patients who were repeatedly abusive.

The practice had a record of families who were using the local food bank voucher system to support the family diet so that staff were aware and could offer additional dietary advice or support if needed.

The practice provided support for vulnerable people. For example we saw that the practice registered a homeless person using the practice address. There were repeated efforts to try and get the individual to engage more closely with health services.

Care planning and involvement in decisions about care and treatment

Patients said that the GPs and the nurse discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive. Patients also received appropriate information and support regarding their care or treatment through range of informative leaflets. Patients' comment cards and the patients we spoke with reported that they felt listened to and they felt the care was good.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 72% of practice respondents said the nurse involved them in care decisions and 79% felt the nurse was good at explaining treatment and results. Both these results were above the regional average.

The practice monitored patients who had attended the emergency department (A&E) of the local hospital. The practice telephoned patients who had attended A&E within three days (of being notified of the attendance) to check that they were safe and to talk through the reasons for the admission so that the practice could help in the future. The practice also rang patients, who frequently attended A&E for minor ailments, within one or two days of being notified of the attendance as a "comfort call", to see how they were and to mention to them that they could be seen in future at the surgery or by telephone consultation.

The practice had a scheme to review unplanned admissions of patients to hospital. As part of this patients who had been admitted were contacted and, where appropriate, had individual care plans. Patients were also encouraged to have summaries of their condition and treatment at home for the use of out of hours GPs or ambulance staff. Patients had said that they found these summaries and care plans reassuring.

Are services caring?

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 to get access to services such as those related to disability. The GPs and nurses worked with the staff involved in palliative (end of life) care. There were quarterly meetings where patients' spiritual, as well as physical, needs were discussed. There was a system for identifying the stage of care patients needed so that all the team were aware of an individuals' needs.

Notices in the waiting room and practice website also told people how to access a number of support groups and organisations. The practice had a protocol so that staff could identify patients who were carers or were cared for. The practice's computer system could then be used to alert staff so that they could adjust their response accordingly. We also saw written information available for carers to ensure they understood the various avenues of support available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients needs and had systems to maintain the level of service provided. The needs of the practice population were understood. We saw the practice had identified several key issues such as patient turnover and that, because of the nearby campus, about a fifth of the population were of student age. In response to this the practice attended fresher's week to provide guidance on student health. The practice considered individual's needs, for example a one patient with particular needs always had an early morning appointment so as to minimise the impact on their daily activities. Patients experiencing mental health problems were allocated longer appointments. Reception staff told us that they could access a list of patients who had acute mental health problems so that they could be given priority if they called the practice for help. The practice made regular visits to local care homes, for the elderly, and were aware of which care homes required more attention than others.

The NHS England Area Team and local clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that the practice had responded to a CCG quality improvement initiative aimed at improving access for patients. Once a month there was joint clinic (working with the CCG) to fit long-acting reversible contraception coils and implants. The practice had found that there were many foreign students who accessed these services

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The group had raised the issue of confidentiality at the reception and suggested that patients stay behind a red line until called forward. The practice had implemented this and feedback from the PPG had been that patients were in favour of it.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. A GP from the practice had spent a day at a local care home ensuring that older patients received their vaccinations and that their

medicines reviews and annual health checks were up to date. The practice had produced advisory notes for the considerable Eastern European community in the area. This explained some of the primary care services available in the United Kingdom. This was in response to demands from Eastern Europeans to be referred to secondary care for services such as cervical smears because that was their expectation. These advisory leaflets were available in Gujarati, Russian, Lithuanian and Latvian.

The practice was aware of telephone translation services and would use them if required. Generally however translation services were obtained from the local authority. There was a folder in the reception which gave an "instant translation" to common medical emergencies such as painful conditions or shortness of breath across a very wide range of languages. Staff said that this was particularly useful.

There were staff available who spoke Slovak, German, Russian Gujarati and Hindi. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities. There was an external ramp so that patients with mobility problems could access the practice.

Access to the service

The practice was open to patients from 8am to 6pm Monday to Friday. There was always a GP on duty for those who needed urgent access. When this happened the GP telephoned the patient to assess their needs. There were six emergency slots for each GP each day. Some patients said that it was difficult to get appointments. Appointments could be booked up to six weeks in advance. Most appointments were available by telephoning on the day. This did cause problems for patients who could not get through on the telephone before the appointments were filled. The practice had identified that the problem was caused by the numbers of patients who did not attend (DNA) their appointments.

The DNAs for August, September and October were 262, 326 and 341 across College Health Boots and the sister site College Health Stirling House. The practice had discussed this with the PPG. The practice had tried a number of different methods to reduce this including text messaging and changing the system of booking appointments. This

Are services responsive to people's needs?

(for example, to feedback?)

high rate of DNAs had an adverse impact on the remaining patients who were trying to book appointments. In consultation with PPG the practice had instituted a policy whereby if a patient missed three appointments in six months without notice the patient was only able to book on the day and not in advance.

The practice had collaborated with Ashdown Medway Accommodation Trust (AMAT). AMAT is a charity providing provide temporary accommodation and intensive support to homeless people. The practice provided support and health promotion clinics. Patients who were homeless were accepted at the practice. Many of the patients coming from these backgrounds had complex problems and the practice allowed for this by having longer appointment slots for these patients. The receptionists were aware of this and would book longer slots if needed.

Listening and learning from concerns and complaints

There was a complaints policy. It included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage all complaints. We looked at the complaints log. We looked in detail at four complaints. There had been an effective investigation. There had been learning from complaints. We saw that these were discussed in meetings. The complaints were replied to courteously and the complainant informed of the outcome of the investigation. There were some inconsistencies in the earlier complaint response letters we looked at, however the practice now used a standard template for the structure of the letters so that inconsistencies were eliminated.

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 staff we spoke with told us that they felt well led. The GPs and the practice manager said that they advocated an “open door” policy and all staff told us that the GPs and practice manager were very approachable. All the staff understood the values of the practice, they told us the practice was there to bring the highest possible care to areas of high deprivation where, traditionally, services had been inconsistent. This was reflected in behaviours such as tolerance by the reception staff, who dealt with some difficult and demanding patients, and trying to ensure that patients saw their own (preferred) GP whenever possible.

Governance arrangements

The practice had a number of policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of policies and saw that they were dated and had been read by staff. All the staff had an office procedure and employee handbook to guide them through day to day processes.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The high turnover of patients, resulting in part from the high student population, meant that some of the QOF data appeared inconsistent with the data from other local practices. The practice had recognised this and had carried out reviews including comparing their demographics with nearby practices. The QOF results had been independently examined and showed the practice was performing in line with national standards. We saw that QOF data was regularly discussed at meetings and individual staff members were tasked with actions to maintain or improve outcomes for patients.

The practice had completed a number of clinical audits. There was a recent audit of outpatient referrals. This had led the practice to consider whether some of the referral pathways were effective and whether other services they provided were well understood by the patients. There had been changes to practice but it was too soon to have a follow up audit. Other actions arising from examination of referrals to secondary care were to ensure the patient being referred was committed to keeping the appointments and checking that referrals were not being made as “normal practice” without considering the referral criteria and pathway.

The practice had medicines management meetings quarterly. The practice prescribing data was compared with other practices and any advice or plans from the local medicines management team followed.

The practice review of patients attending the emergency department (A&E) had led to changes in services. For example Friday afternoon was identified as “peak time” for patients going to A&E so the practice had increased the number of appointments available at that time.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said that they would interrupt a consultation if they had an urgent concern and GPs supported this. There were regular staff meetings and we looked at the minutes of some of these. Staff were updated by the management about changes both within the practice and those affecting the local health economy. For example the meetings discussed issues ranging from the management of correspondence coming into the practice and the care planning of patients at high risk of hospital admission.

Staff had job descriptions that clearly defined their roles and tasks at the practice. There were processes to identify and respond to poor or variable practice. We saw that the practice had addressed recent concerns about staff absence and there had been training for relevant staff in managing absence. We saw a further example concerning staff conduct, as opposed to staff absence. The appropriate disciplinary processes were followed and the practice dealt with the concerns.

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

The practice obtained feedback from patients through a variety of means, including complaints, patients’ surveys and the practice patient participation group (PPG). The issues raised included opening hours, the availability of appointments, confidentiality at the reception desk and the problem of those who did not attend for appointments.

At the suggestion of the PPG a red line had been placed in front of the reception desk and patients were asked not to cross it until called forward by a receptionist. This had greatly increased confidentiality. With regard to opening hours the practice had tried various permutations of opening hours, including Saturday morning opening, and was testing what was most effective. The PPG was

Are services well-led?

Good 

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

conducting a questionnaire to gain further ideas and comments from patients. The PPG suggested that most patients were unaware that appointments could be booked up to six weeks in advance. The practice had tried to increase awareness of this through notices and through information provided by the receptionists.

We saw from the minutes of staff meetings that staff contributed to the running of the practice and their concerns were listened to. For example staff expressed concerns about dealing with difficult or aggressive patients and the management had responded by arranging for the staff to attend a course specifically to address these issues.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place.

The practice was a training practice and all the GPs and nurses were to some degree involved in the training of future GPs. The quality of GP decisions was therefore often under review. In addition the practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (called the Deanery). Trainee GPs were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. The practice also took nurses under training into the practice from the local university so that staff were exposed to the most recent clinical training practice.

The practice had completed reviews of significant events and other incidents and had shared the findings with staff at meetings to ensure the practice improved outcomes for patients.