The Oaks Partnership

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection at The Oaks Surgery on 21 October 2014. During the inspection we gathered information from a variety of sources. For example; we will spoke with patients, members of the patient participation group, 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 well-led, effective, caring and responsive services. It was also good for providing services for the care for the care of older people, people with long-term conditions, for the care of families, children and young people , for the care of working-age people, for the care of people whose circumstances may make them vulnerable and for the population group people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.
- People's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs have been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

However there was one area of practice where the provider needs to make improvements namely:

- The practice should improve its recorded supervision for nursing staff who are independent prescribers.

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 report incidents and near misses. Staff demonstrated a culture of openness to reporting and learning from patient safety incidents. 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 people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. 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. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Evidence showed that 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. Treatment and options were explained to patients. 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 patient confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a preferred GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to

Summary of findings

treat patients and meet their needs. 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 with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a preferred GP and 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 an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

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 good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. These patients were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who were on the child protection register or who had a high number of attendances at accident and emergency. Immunisation rates were relatively high for all standard childhood immunisations. We saw examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

Summary of findings

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 and those with a learning disability. It had carried out annual health checks and follow up appointments for patients with a learning disability. It offered longer appointments and appointments at suitable times for patients with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group people experiencing poor mental health (including people with dementia). We saw that the practice worked in co-operation with the local mental health team. There had been a review of the use of the dementia pathway by the practice leading to marked improvements in the diagnosis of dementia. The practice had reviewed its diagnosis of mental health generally and in consequence the practice's prevalence of patients with mental health problems was now closer to that expected locally.

The patient participation group had organised public events on dementia with talks from GPs, local charities and the Alzheimer's society. There was a counselling service available at the practice.

Summary of findings

What people who use the service say

We spoke with three patients. We received 14 completed comment cards. The visit was announced on the practice website and people were asked to send their comments to the CQC lead inspector whose e-mail address was provided, from this we received eight e-mails.

All the patients were pleased with the quality of the care they had received. 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 telephone system was a considerable improvement.

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 292 survey forms were sent out and 128 were returned. The main results from that survey were:

What the practice does best

- GPs good at listening to them
- Patients with a preferred GP usually get to see or speak to that GP.

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What the practice could improve

- Patients find it easy to get through on the phone
- Patients waiting time to be seen

Since the survey the practice has had a new telephone system installed and patients report that this is an improvement. The practice has also worked to streamline processes in reception so that patients wait less time.

Areas for improvement

Action the service SHOULD take to improve

The practice should improve its recorded supervision for nursing staff who are independent prescribers.

The Oaks Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Oaks Partnership

The Oaks Practice is located in the town center. There is ample parking nearby. There are seven GP partners. There are two male and five female GP partners. There is one male salaried GP. There are four practice nurses, all female. The surgery is purpose built and all the consulting and treatment rooms are on the ground floor. The practice is a training practice. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

The practice is situated in a densely populated urban area and has a registered patient population of approximately 10,700, covering Swanley and the surrounding villages. The practice had fewer patients in older age groups and more in the younger age groups than the national average. The number of patients recognised as suffering deprivation was the same as the local average but higher than the national average. The number of patients with long term medical conditions was more than the CCG average and more than the national average.

Services are delivered from

The Oaks Surgery

Nightingale Way

Swanley

Kent

BR8 7UP

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 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

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" in their surgeries.

Detailed findings

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 on the practice website and people were asked to send their comments to the CQC lead inspector whose e-mail address was provided. 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 21October 2014. During our visit we spoke with a range of staff including; GP partners and salaried GPs, 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)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. There was a log of significant events. One event had concerned the spillage of a specimen that had been taken from a patient. The patient was informed of what had happened. The practice sought advice from a professional association as to what action to take and followed this advice. The reasons for the spillage were investigated and new processes put in place. The incident was discussed at the partners' significant event meeting. A letter was sent to the patient advising them of how the incident had been dealt with.

Staff we spoke with said that there was an ethos at the practice where anyone could report concerns without any anxiety. They knew to whom significant events should be reported. We reviewed safety records of incidents going back to April 2013 and this showed the practice had managed these consistently. The partners held a regular meeting to discuss significant events. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff.

There were notices for staff at strategic points about the practice reminding them that patient safety was at the heart of all the practice's ethos. A simple diagram showed the various stands such as safeguarding and governances and who was responsible for them.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events over the last 18 months. Any individual could report a significant event. We looked at one event where medicines, prescribed for a patient on discharge from hospital were not available for the patient at the practice. There was an investigation where a breakdown in communication between those scanning the discharge letters and those receiving them was identified. All the staff were reminded of the importance of following the protocols for dealing with the discharge letters. An additional notation was added to the process of dealing with the letters so that staff could see if the letter had been actioned.

We saw there was a process for dealing with safety alerts. These were received by the practice manager and, if relevant, forwarded to the GPs and the nurses. We looked at one safety alert from March 2014, relevant to general practice and saw that it had been received and dealt with properly. Staff we spoke with were aware of the system for disseminating safety alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at the practice training records. All the GPs were trained to the appropriate level (level 3). There was a lead GP for safeguarding. That GP had attended more specialist courses such as "Domestic Violence including impact on children and young people" and "Cultural Awareness in Safeguarding". Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They knew who the lead was for safeguarding and to whom these should be reported. Staff had been trained in recognising the signs of abuse in older patients and they knew how to report it

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 for safeguarding met with local health visitors and social services, monthly, to discuss vulnerable children and families, to share information, so that risks could be identified and reduced. When a child did not attend for immunisation reminder letters were sent. If children persistently missed vaccinations the information could be shared with the local safeguarding authority, if the circumstances warranted it, so that the risks to individuals could be considered.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Only nursing staff and healthcare assistants were used as chaperones. There were seven trained staff available and two staff who were awaiting training, their records were noted as not to be used as chaperones (until trained). There were sufficient staff available to meet the demand for chaperones.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators 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. Although the medicine refrigerators were not "hard wired" into the electrical system, the sockets that they were plugged into could not easily be reached. Therefore it was very unlikely that staff, such as cleaners, could accidently unplug the refrigerators. We looked at the processes to check 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 properly.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The nurses who administered the vaccines had all been trained and their qualification had been renewed for the current year. A member of the nursing staff was qualified as an independent prescriber. We were told that they received regular prescribing audits from the local medicines management team and these were reviewed with the GP prescribing lead. However there was no record of any regular supervision. The prescribing nurse attended meetings where significant events were discussed and was an integral part of the significant event process.

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

Cleanliness and infection control

The practice had an infection control policy, which included procedures and protocols for staff to follow, for example, hand hygiene, clinical waste, and personal protective equipment (PPE). The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with PPE including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for patients to use and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice.

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

The practice had recognised that the decoration and internal fabric of the building was dated and not fully compliant with the latest guidance. For example not all the floors were covered with a single sheet of material or coved up the walls. Some taps were not elbow operated and sinks had overflows. This made it more difficult to maintain modern hygiene standards. However the practice was cleaned regularly to a high standard. The practice had carried out a comprehensive assessment of the work needed and had a refurbishment plan. Some work has already been completed such as replacing fabric covered chairs with washable chairs. In other areas quotations to carry out the work had been accepted and awaited timescales for completion.

In minor surgery only disposable instruments were used.

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 and appeared in good working order.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at staff files and saw that for example, 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.

We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. The rota system ensured that staff, including GPs, nurses

Good

Are services safe?

and administrative staff covered each other's annual leave. The practice had assessed the staffing levels and had identified a shortage in the numbers of receptionists. There was a plan to recruit additional receptionists.

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. 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.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we saw that the progress of the building refurbishment plan was regularly discussed at meetings.

Arrangements to deal with emergencies and major incidents

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. Staff checked that emergency medicines were within their expiry date and suitable for use and when we looked we found the emergency medicines were in date. There were up to date business continuity plans to manage foreseeable events such as loss of utilities. The continuity documents contained relevant contact details for staff to use in the event they needed to report business continuity issues.

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 treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. There were regular reviews of patient care and treatment in line with NICE guidance. Patients' calls were screened by receptionists to ensure that they did not need immediate referral to a GP or nurse. Receptionists told us of the warning signs they used such as chest pains, dizziness or numbness. The decisions were based on experience and training they had received in the practice and protocols available to them.

We talked with the GPs and nurses and they said that they completed assessments in accordance with NICE guidelines. We saw for example in meeting notes that practitioners knew of certain NICE guidance on motor neurone disease. Namely that it advocated spirometry checks, that is checks to assess how well the patient's lungs work, every six months. We looked at records, which had been anonymised and saw that there had been thorough assessments of patients' needs and these were reviewed when appropriate.

There was a range of nurse appointments available to patients. This included chronic disease management – such as diabetes, asthma, heart disease and chronic obstructive pulmonary disease (COPD). The senior GP partner showed us how the practice benchmarked itself against data from the local clinical commissioning group, the local NHS England area, and national benchmarking tools. This had led to a number of reviews. For example the practice had reviewed how individual GPs prescribed a particular drug used to relieve feelings of sickness or being sick. This led to some changes in practice but showed patients were on appropriate treatment and regularly reviewed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The QOF data for this practice showed the practice generally in line with other similar practices.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. There was an audit plan. This set out a regular schedule of audits. These included cleaning audits, management of medicines and unplanned admissions (to accident and emergency) audits. We saw that these were discussed at the monthly clinical governance meetings. For example we saw an audit of the treatment of patients affected by gout. There were reasons and criteria for the audit. The audit suggested room for improvement. The improvements were implemented and, when checked later on in the cycle, had been maintained.

We saw that the practice's clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example we saw an audit of inadequate samples of cervical smears. This showed that the practice was well within the range expected. The information for the audit was collected at the level of individual GPs and nurses so that the individuals could learn from any mistakes to improve their technique. We saw that there was a process to recall patients whose smears were inadequate so that their screening could be completed.

The practice provided an enhanced service in respect of patients who were at high risk of unplanned admissions to hospital. Many of these were older patients, those with long term conditions or mental health problems. We saw this included, in some cases, a personalised care plan involving the patient and which was supervised. Patients who had unexpectedly attended the emergency department were telephoned by staff from the practice to see if any further follow up was required.

The practice reviewed the patients that it had referred to the rapid access elderly care clinic. This clinic allows GPs to refer, to secondary care, certain elderly patients with symptoms which require investigation by a physician often using tests not available to general practice. The practice found that there had been a significant reduction in these referrals between 2012 and 2013. The practice felt that they were managing more of these complex cases in the practice, probably because of the increased presence of the community respiratory and heart failure nurses and so reducing the numbers of elderly patients being admitted to hospital.

Good

Are services effective?

(for example, treatment is effective)

Support for patients with term conditions included dedicated nurse sessions with a recall system that alerted patients as to when they were due to re-attend. These services were there to support patients with chronic obstructive pulmonary disease, asthma management and smoking cessation issues. The practice regularly reviewed patients with long term conditions. For example they recently carried out an audit of patients with atrial fibrillation, which is an irregular heartbeat, to determine whether the practice was following the recognised pathways for their treatment. From the audit we saw that patients' diagnosis and treatment were discussed with them. Options were explained and when patients needed time to decide their option they were able to take that time. The audit concluded that, while not all patients fit perfectly into a pathway, on the whole patients were receiving treatment recommended in the pathway in a timely manner appropriate for each patient.

Patients over the age of 75 had been allocated a dedicated GP to oversee their individual care and treatment requirements. There were annual flu vaccination clinics for older patients, patients with long term conditions, vulnerable patients and for patients for whom it was recommended such as pregnant women and those with weakened immune systems.

Effective service for children and families included nurse appointments for cervical and post natal checks. We saw there were regular audits of gynaecology referrals where staff checked that the referrals were appropriate. There had been a review of the practice's use of the menorrhagia treatment pathway. This was used when a patient presented with heavy menstrual bleeding. We saw that treatment options were discussed with the patients. Leaflets were used so inform patients so that they had information to take away, read and investigate for themselves. When patients were referred to secondary care for treatment each referral was reviewed by a named GP in the practice who specialised in this field.

All children who requested appointments were reviewed by a GP on the day by telephone consultation or surgery consultation. The practice had carried out an audit of patients of less than 15 years of age who had attended the emergency department (A&E). The reasons were identified and patients followed up as required.

There had been a review of the use of the dementia pathway by the practice. This was based around an examination of the number of general practitioner assessments of cognition (GPCOG). The GPCOG is a screening tool for cognitive impairment. Assessments were up from 4 to 27 when compared with the previous year. The conclusion of the review was that the practice had driven a large increase in assessments which had improved the practices' earlier diagnosis rates. This was consistent with the Quality and Outcomes Framework (QOF) data for the practice which showed that the prevalence of dementia, that is the number of patients diagnosed with dementia as a percentage of the practice population, was over one and a half times more than the average for the local clinical commissioning group.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records. There was an overall training plan. We saw that 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 fire safety training. We saw that in September there had been a fire safety training day run by the local NHS facilities department. Staff had protected learning time and they undertook training as a group which allowed them to share learning experiences. We saw learning time had been used to keep staff informed about changes to the practice and to allow them to have an input into plans for the future.

The practice maintained a record which showed that all the GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. 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 with the objectives, such as training.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage their care. Blood results, x-ray results, letters from the local hospital including discharge summaries and information from out of hours providers were received through a of variety means. These were scanned into the patients' notes and the practice had

Good

Are services effective?

(for example, treatment is effective)

trained a new member of staff to do this. It also had plans to increase the numbers of staff available to do this. All staff we spoke with understood their roles in the system and usually it worked well. There had been an incident when the system had broken down because of a failure in communication. This had been investigated and the system improved to make it less likely that it would fail again.

There were regular multi-disciplinary team meetings. We looked at the minutes of these meeting and saw that they involved various professionals from outside and inside the practice, for example, district nurses, social services, GPs and other specialists. 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 matters. The practice had agreed to be part of a pilot scheme with the local hospice and community nursing teams called Planning for Change which was focussed on improving end of life care.

The practice worked with the local ambulance service. Where the practice received a call from the local ambulance service concerning a patient, they offered the patient a same day contact, either as a duty appointment, a home visit or telephone consultation. The practice found this process was very effective in avoiding A&E attendances. For example audit had shown 14 patients who called an ambulance, were diverted to the practice and seen quickly so as to avoid emergency attendance and possible admission.

We saw that the practice worked in co-operation with the local mental health team in managing patients with mental health problems who were frequent attenders at the local accident and emergency department. The practice was working with other providers, including the local mental health trust, to provide integrated primary care teams to help mental health patients who moved between providers.

The prevalence of patients with mental health problems, that is those diagnosed with a mental health problem, had, historically, been much lower in the practice than locally and nationally. The practice had recognised this and had, over the last few years, worked hard to identify patients with mental health problems. In consequence the practice's prevalence of patients with mental health problems was now closer to that expected locally.

Information sharing

The practice had systems in place 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.

The lead for safeguarding met with the local health visitors and social services, monthly, to discuss vulnerable children and families, to share information, so that risks could be identified and reduced.

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. We saw that consent was specifically recorded for intrusive procedures such as minor surgery. The minor surgery appointments were pre-booked so that the procedure could be explained. There were leaflets available to help patients understand the procedures, and consent was obtained in advance.

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 notice. There had been no cause to hold any "best interest" meetings for patients who lacked the capacity to make decisions for themselves.

Health promotion and prevention

We were told that all new patients were offered a health check. They were given a questionnaire and the nurse appointments included a new patient check. We looked at anonymised records of new patient assessments and saw that they were thorough. Those on repeat medications were referred to the appropriate specialist clinic in the first instance and to a GP if necessary.

There was a range of leaflets available in the reception area. There was also a television screen in the waiting room that delivered health promotion messages. These sources provided health promotion and other medical and health information for patients. The practice website provided access to information in languages other than English. There was access to translation services though facilities

Good

Are services effective?

(for example, treatment is effective)

provided by the local authority. There was information about appointments, clinics and other services on the website. The practice website also provided links to other useful sources of information including various cancers, mental health, AIDS, epilepsy and other health promotion advice. The practice was actively ensuring that there was access to information to assist patients in making decisions about their care. Specific health promotion literature and details of services were available to older patients, patients with long term conditions, vulnerable patients, mothers families and young people and those with mental health problems.

The practice had held educational events to support patients with long term conditions, for example a diabetes event. The event also alerted people to other services that might be of help to them. We read patients' comments that praised this event in particular for knowledgeable and engaging speakers.

The patient participation group had organised two three-hour sessions, open to the public at the town hall and advertised locally for people to come along and learn about dementia. The talks were given by GPs from the practice with contributions from local charities and the Alzheimer's society. They were held as an educational event to support patients, their families and carers affected by dementia. They were extremely well attended. This event also alerted people to other services that might be of help to them. We read patients' comments that praised this event as well as the care that their family members, suffering from dementia, had received.

The practice had also identified some 1500 patients over the age of 15 who were smokers and had offered smoking cessation clinics to 90% 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 vaccines and flu vaccinations in line with current national guidance. There were follow up mechanisms in place for those who did not attend.

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 to patients, we received e-mails from patients and read the comment cards that patients had completed.

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 busy and it there were difficulties in maintaining patient confidentiality. However staff appeared aware of this and talked quietly so that it was difficult for them to be overheard. The practice reception telephones were located away from the reception desk so that patients could not easily overhear what was said. There was a notice asking patients to wait away from the reception desk until there was a free space. This reduced the likelihood of patients overhearing private conversations between patients and reception staff. Plans had been drawn up to refurbish the reception area to include transparent partitions that would increase privacy. 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 e-mails and comment cards. 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 necessary.

Repeat prescriptions were collected from the practice by staff from the local pharmacies. These staff were routinely allowed access behind the reception desk to check and collect prescriptions. When there were discrepancies between the list of prescriptions they were to collect and the bundle of prescriptions that were waiting for them they routinely checked through other prescriptions, sometimes not relevant to their pharmacy, to try and locate any missing ones. We discussed this with the senior partner at the time and, although all these pharmacy staff had signed confidentiality agreements, we agreed that this procedure represented a high risk to patient confidentiality. The practice undertook to review the process so as to ensure that it would cease.

Care planning and involvement in decisions about care and treatment

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. Generally they rated the practice well in these areas. For example, data from the national patient survey showed 70% of practice respondents said the GP involved them in care decisions, 85% felt the GP was good at explaining treatment and results and 95% said that the last GP they saw was good at listening to them.

Patients expressed their views and were involved in making decisions about their care and treatment. We read patients' comments that specifically highlighted how their diagnosis was discussed with them. We looked at an audit of patients with atrial fibrillation, that is an irregular heartbeat. From anonymised records we saw that patients' diagnosis and treatment were discussed with them. Options were explained and when patients needed time to decide, they were able to take that time. There had been a similar review of the practice's use of the menorrhagia pathway. This was used when a patient presented with heavy menstrual bleeding. We saw that treatment options were discussed with the patients. Leaflets were used to advise patients so that they had information to take away, read and investigate for themselves. When these patients were referred to secondary care for treatment each referral was reviewed by a named GP in the practice who specialised in this field.

Patients who used the service were given appropriate information and support regarding their care or treatment. The surgery website provided information in languages other than English. There was no immediate access to translation services, such as language line. The practice said this had not been a problem but that they were aware of these services and would use them if it was necessary. We looked at two anonymised mental health care plans and saw that there was evidence of patients' involvement in them.

There was a counselling service available at the practice for patients who needed access to talking therapies.

Good

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 they get access to services such as those related to specific disabilities. The practice had held public events, one for dementia and one for diabetes, to educate members of the public and to alert them to other organisations providing emotional and practical support.

There were notices in the patient waiting room, on the TV screen and patient website which directed patients to support groups and organisations for carers. There was a protocol for staff to follow to help identify carers. This directed them to alert the patient's GP in circumstances where a carer might be relevant such as discharge and diagnosis letters from hospital or returning home from any kind of care home or long stay environment.

The practice's computer system alerted staff if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The survey information showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, answers to questions about the quality of care such as being treated with care and concern, staff listening to patients or having enough time with patients were positive in 9 out 10 cases. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an active patient participation group (PPG). We spoke with two members of the group. They felt the practice had embraced the principles behind having a PPG. The PPG had conducted a patient survey. As a result of the concerns raised by the survey the practice had upgraded and modernised the waiting area and installed a new telephone system. Patients had commented that the new system was much better than the previous one. There was a regular newsletter "The Patient Voice". This informed patients about subjects such as the chaperoning policy, the progress on the action plan (arising from the patient survey) and health events. There were also short biographies of new staff so that patients could feel involved in the changes that were happening within the practice.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings (MDT) to discuss patients' and their families' care and support needs. The MDT meetings involved other professionals such as district nurses, social services, GPs and specialists.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Patients we spoke with commented that they knew the staff and liked the fact that turnover was low.

There were longer appointments available to patients who needed them for example those with complex or mental health issues. Staff were aware that some patients needed more time and were able to book longer appointments. Services for families, children and young people included; health visitor care, contraception and family planning. There were services for the working age population for example, nurse appointments included the NHS health check for patients aged between 40-74. The practice had extended hours surgeries including those in the early morning specifically for those who had difficulty in attending during normal working hours. The practice provided a telephone consultation service for those patients who were not able to attend the practice.

There was a counselling service available at the practice for patients who needed access to "talking" therapies. Patients could be referred to this by their GP or they could refer themselves to the service.

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. All the treatment rooms were on the ground floor

There was a register of patients who had illnesses which made them particularly vulnerable, for example 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. They were better able to manage their interaction with that person by taking into account any difficulties that the patient might have, such as difficulties in communication or understanding.

Access to the service

Primary medical services were provided Monday to Friday between the hours of 8.00am and 6.30pm. between 12.30pm and 2pm this was for lunch and to allow staff to process administrative work without interruption. The practice aimed to see patients within 48 hours of the request for an appointment. Generally they did so except where a specific GP was requested and that GPs' work pattern prevented this. The receptionists regularly carried out telephone triage. They did this following the training they had received in the practice. There were also protocols for them the follow. Appointments could be booked up to two weeks in advance. There were also book on the day appointments. Each GP was allocated six telephone appointments. The GPs also undertook some e-mail consultations. There were telephone consultations available, on the day, for older patients, patients with long term conditions and vulnerable patients.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients not registered at the practice could access services and interpreter services were available for patients whose first language was not English. We were told that the practice would accept homeless people as patients by using the surgery address or the address of a relative in any registration paperwork. There was a ramp so that patients with disabilities could access the practice. There were documented plans to reconfigure the reception area to provide better access, through a lowered reception desk, for patients with disabilities, such as those in wheelchairs.

The practice had extended hours opening between 7.10am and 7.50am for patients who found it difficult to come to the practice during normal opening hours, for example because they were working. In the recent NHS patient survey for the practice 100% of patients said that they had been able to get an appointment when they wanted to.

Listening and learning from concerns and complaints

There was a complaints policy in place. 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. There had been learning from complaints. We saw a complaint related to a patient with chest pains. The complaint was investigated and was partially upheld. It was discussed by the partners who consulted current national guidance and amended their practice to reflect the guidance.

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 and described a practice that was open and transparent. Staff consistently said that they understood what the practice stood for, for example trying to ensure that patients saw their own (preferred) GP whenever possible and trying to respond to patients needs to the best of their ability at all times. The GPs and the manager said that they advocated an "open door" policy and all staff told us that the GPs and practice manager were very approachable.

Governance arrangements

Clinical governance was covered in a range of meetings. There was a weekly meeting between the practice manager and the senior partner, there was a practice meeting every third week, practice nurse meetings and significant event meetings. In these meetings areas such as practice hygiene, training and personal development and concerns raised at the practice meetings were addressed. We looked at the minutes of some meetings. We saw they covered practical aspects of keeping patients safe, such not over stocking fridge drawers so that it was easier to check expiry dates and suggestions about ensuring stock rotation was effective. Performance, quality and risks were discussed. There were other more specialised meetings such as those with the local hospice or local psychiatric nurses who were seconded to the practice. These addressed concerns such as unplanned admissions to hospital.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at meetings and there were plans to maintain or improve outcomes.

The practice had completed a number of clinical audits, for example the effectiveness of emollients (non-cosmetic moisturisers) which resulted in changes to the products that the practice used. There was an audit of the post-operative infection rate in minor surgery, which was found to be well inside what was considered to be the "norm". There was an audit of a diabetic medicine to ensure it was not being prescribed to patients with possible kidney disease. The audit was completed and no patients at risk were found to have been prescribed this medicine.

Leadership, openness and transparency

There was a chart that set out the leadership structure and responsibilities of the various staff members. For example the leads on stock control, minor operations and prescribing were set out. Staff we spoke with knew who the leads were for various subjects.

We saw from minutes that there were regular team meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff we spoke with said they felt they would be listened to if they wanted to raise an issue as a safeguarding or whistleblowing.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example infection prevention control, chaperoning and whistleblowing. They were up to date. Staff knew where to find the policies.

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 surveys and feedback had consistently highlighted that patients were unhappy with their ability to get through on the telephone. As a result the practice had installed a new telephone system. This had only recently been completed but early feedback from patients was that it was a considerable improvement.

The practice had an active patient participation group (PPG). The patients and the practice wished to extend this but felt that a direct increase in membership would make meetings unwieldy and more expensive, as larger meeting rooms would have to be found. They decided to increase participation through the "patient reference group" this was a virtual group of patients, who did not wish to attend the meetings but were available through e-mail to contact and to comment on proposals. The PPG members we spoke with said that this had increased the reach of the group to include more patients who were of working age, mothers with families and patients with disabilities who had found it difficult to attend the meetings.

The PPG had been involved in a number of changes at the practice including producing a patient newsletter, conducting a patient survey, changes to the telephone system and advertising practice events such as diabetes

Are services well-led?

Good

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

and dementia information events. There was a television screen in the waiting room that delivered health promotion messages. Members of the PPG suggested that the "turnover" of the messages was too quick for patients to easily absorb them. The practice therefore changed them so that each message ran for a longer time. Several actions arose out of the PPG patient survey. Many had been completed including, notices in the waiting area advising patients that they can talk to member of staff in private if they wish and replacing the patient check in machine.

Management lead through learning and improvement

Staff told us that they felt well supported with the practice. There was regular training. Staff said that appraisals were used to identify training needs and aspirations. We saw that there were plans for administration staff to manage their own meetings with different staff members taking on the role of chair. The managers felt that this would lead to staff being more involved and empowered in the practice.

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 had completed reviews of significant events and other incidents and shared with staff during meetings. For example recent safeguarding issues had led to increased training and awareness amongst staff to ensure the practice improved outcomes for patients.