

St James Medical Centre

Quality Report

ST James Medical Centre,
11 Carlton Road,,
Tunbridge Wells,
Kent.

TN1 2HW

Tel: 01892 541634

Website: www.stjamesmc.co.uk

Date of inspection visit: 10 February 2015

Date of publication: 23/07/2015

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	10
Background to St James Medical Centre	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St James Medical Centre on 10 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services.

It was also good for providing services for the care of older people, the care of people with long-term conditions, the care of working age people (including those recently retired and students), the care of families, children and young people, the care of people whose circumstances may make them vulnerable and the care of people experiencing poor mental health (including people with dementia).

- 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, staff and to the building were assessed and well managed.

- 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. Some issues relating to the building were unresolved from the time of our last inspection. However the practice had a planning application lodged with the local authority to extend the premises, which would alleviate the problem.

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.

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

Importantly the provider should:

- Review its auditing activity to help to ensure its effectiveness and to more closely reflect the population it serves.
- Improve its recording of patients who had, or were, carers so that they could be more easily identified on the practice computer system.

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

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multi-disciplinary teams.

The practice worked in cooperation with other providers and the voluntary sector.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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. Information about how to

Good



Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evident.

Are services well-led?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evident.

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 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.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and 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 multi-disciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Parents of children who called with urgent matters were seen as soon as possible and, in any event, on the day they called.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

to help to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

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 including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had been offered an annual health check. It offered longer appointments for people with a learning disability. The practice used clinically recognised risk stratification tools to identify patients with complex needs to help to ensure that there were multi-disciplinary care plans documented in their case notes. The practice worked with a Street Pastors scheme, to identify and care for homeless people. The practice worked with the Street Pastors scheme, to identify and care for them. The practice worked closely with local drug and alcohol support services and had a long history of providing care to this group. Vulnerable patients who had a care plan had priority in the allocation of appointments and the computer system alerted reception staff to these patients when appointments were made.

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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety four per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Where patients had been identified as having memory problems, staff telephoned them if they had missed an appointment to check if they were alright and to identify the reason why the appointment had been missed. When staff accessed the notes of patients whose illnesses which made them particularly vulnerable, for example a

Good



Summary of findings

learning disability, dementia or end of life care a message was displayed on the computer screen to inform the staff member of the diagnosis. Thus 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, memory or understanding. Patients with mental health problems could ask for longer appointments.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

We spoke with five patients. We received 21 completed comment cards.

All the patients we spoke with were pleased with the quality of the care they had received. The themes that ran through our conversations with patients and the remarks on the comments were that it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment. Patients often saw their preferred GP. Several patients commented that the reception staff were very friendly and efficient and that the GPs, nurses and healthcare assistants listened to what patients said.

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 228 survey forms were sent out and 125 were returned. The practice had good results from the survey. For example in the section “seeing or speaking with your preferred GP” the practice was above the average for the clinical commissioning group (CCG) and nationally. In the section “for overall experience with the practice” the practice was also rated significantly better than the CCG average.

Areas for improvement

Action the service **SHOULD** take to improve

- Review the auditing activity to help to ensure its effectiveness and to more closely reflect the population it served.
- Improve the recording of patients who had, or were, carers so that they could be more easily identified on the practice computer system.

St James Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St James Medical Centre

The St James medical Centre is a GP practice located in an urban area of Tunbridge wells. It provides care for approximately 5,750 patients. The practice population is similar to national averages. It has marginally more patients under 18 years old and about a quarter more patients over 85 years than the national average.

It is not an area of high deprivation or of high unemployment. It is not in an area of income deprivation. It has nearly twice the number of nursing home patients than the national average.

There are three GP partners, two female and one male there is one female salaried GP. There are 26 GP sessions each week, one session being half a day. There is a nurse and a healthcare assistant (HCA) providing approximately 16 combined nurse and HCA sessions weekly. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a training practice.

Services are delivered from:

ST James Medical Centre,
11 Carlton Road,
Tunbridge Wells,

Kent

TN11 2HW

01892 541634

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care which is provided by Integrated Care 24.

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.

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 and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 10 February 2015. During our visit we spoke with a range of staff including GP partners, salaried GPs nurses and healthcare assistants, receptionists and administrators. We spoke with patients who used the service.

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

- Is it safe?
- Is it effective?

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

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

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

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, significant events or incidents and national patient safety alerts as well as comments and complaints received from patients or other providers. The staff we spoke with understood the policy relating to significant events and were aware of their responsibilities to raise concerns. Staff told us that the practice had made it clear that they could report concerns anonymously if they felt this necessary. They knew how to report incidents and near misses. There was a wide range of significant events recorded by the practice.

For example we saw that there had been an issue regarding a patient's identity that had been raised when a prescription was received at a local pharmacy. This had led to staff training and to additional measures to ensure that a patient's full name was checked.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. There was regular reporting of events, 27 events being reported in that period. This showed there was a positive ethos in the practice to report significant events where staff were in any doubt.

Learning and improvement from safety incidents

The practice had systems for reporting, recording and monitoring significant events, incidents and accidents. Staff completed a template form that was forwarded to the practice manager and investigated. The incidents we looked at had been investigated in a comprehensive and timely manner.

The significant event log included details of any action plans to reduce risks and who was responsible for their implementation. Significant events were discussed at regular meetings, formally by the GPs and practice manager every three months. However records showed that action was taken to inform staff as soon as any learning from the event was identified.

Learning from these meetings had included refresher training for prescription staff and improvements to the audit trail for certain types of documents received at the

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

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at the practice training records. All the GPs were trained to the appropriate level (level 3) in safeguarding children. Most GPs had also completed training in safeguarding adults though one GP had not and this was booked in the near future. There was a lead GP for safeguarding both children and adults. 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 to the appropriate level. There were notices and flow charts at various places within the practice to remind and inform staff about the processes to be followed in reporting a safeguarding matter. GPs told us about specific incidents, involving children, that had been correctly reported and investigated in accordance with the protocols. The lead GP for safeguarding was aware of vulnerable children and adults in the practice and regularly liaised with other agencies such as the local authority and local social services.

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. This system was also used for patients who were vulnerable for clinical reasons such as those who needed particularly close monitoring of their blood. These patients were identified by reception staff when they contacted the practice for appointments and the appointments made included any of the outstanding matters so that they could be dealt with the same time.

Are services safe?

Where these patients remained difficult to contact, such as homeless patients, specific reception staff were tasked with continuing to try and make contact until the matter had been resolved and they recorded their efforts on the patient's electronic record. We saw several examples where staff continued to try and contact patients in such cases.

There was a chaperone policy. There were posters about chaperoning displayed on the waiting room noticeboard and in consulting rooms. There were sufficient staff trained to act as chaperones and they had been trained to do so. When a chaperone was used this was noted on the patient's record. There were plans to train and use reception staff as chaperones and the practice was awaiting criminal record checks from the Disclosure and Barring Service before proceeding with this.

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 to help ensure that medicines were kept at the required temperatures. Temperature checks were recorded in accordance with the policy. There was guidance on the action to take in the event of an equipment failure. There had been an incident where the refrigerator had been switched off by mistake, the correct policy had been followed. The practice had bought a socket cover to help to ensure that the same mistake did not happen again.

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

The patterns of antibiotic, sedative and anti-psychotic prescribing were within the range that would be expected for such a practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The nurses and the health care assistant administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions for

various medicines had been signed by the staff concerned and signed copies were retained on staff files. There was evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

Cleanliness and infection control

The premises were clean and tidy. The treatment and consulting rooms were clean, tidy and uncluttered. Antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice. The fittings within the building were modern and compliant with recent guidance.

The practice had a lead for infection control who had undertaken an accredited course to enable them to provide advice on infection control and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. Audits had been carried out and these had resulted in changes such as to the type of soaps used by the staff. The audits had identified that some of the consultation and treatment rooms needed more modern foot operated waste bins and these had been provided. There were notices in the consulting and treatment rooms as to what action to take in the event of a needle stick injury.

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

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

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and there was a schedule for ensuring that

Are services safe?

was carried out when required. All the equipment we looked at had been calibrated and there were labels on the equipment showing when this had taken place and when it was next due.

Staffing and recruitment

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

There was a rota system for all the different staffing groups to help to ensure that there were enough staff on duty. The practice was aware of the problems that might occur when there were insufficient numbers of trained receptionists. They had recruited additional reception staff and these were undergoing induction training at the time of the inspection. The rota system ensured that staff, including GPs, nurses and administrative staff planned to cover each other's annual leave.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Records showed that staff were up to date with fire training.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support (BLS). There was BLS refresher training scheduled every 18 months for all staff. Emergency equipment was available including access to medical oxygen and to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We checked the emergency medicines, we found one out of date item which was replaced immediately.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The document contained comprehensive instructions and contact details of services which might be needed in such an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, nursing staff and healthcare assistants (HCA) we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). They were able to access the local clinical commissioning group (CCG) guidance from terminals in their consulting rooms. The practice had its own templates for long-term condition patients. We looked at those for chronic obstructive pulmonary disease (COPD), asthma and diabetes. They were comprehensive and incorporated other guidance such as that from NICE. There was a range of guidelines for other long-term conditions and guidelines for different cancer referral routes. Other examples of guidance included the use of the Cardiff health check template for patients with a learning disability.

There were weekly meetings of GPs and nurses where new guidelines were disseminated, recent safety alerts cascaded and the practice's performance discussed. Where the practice identified problems specific GPs or nurses were tasked to address them. Staff also took the opportunity to talk about complex cases. All the staff we spoke with were open about asking for and providing colleagues with advice and support.

The available data showed that the practice's performance for most prescribing was in the same range as other similar practices. The pattern of hypnotic prescribing was outside the normal range. We discussed this with the GPs they told us that the practice was involved in initiatives to assist vulnerable patients such as the homeless and those with health concerns relating to substance misuse. Therefore the practice's population of patients treated with hypnotics was greater than the average for the locality and thus the amount of hypnotic medicines prescribed was greater than that locally.

The practice was commissioned for the new enhanced service designed to prevent unplanned admission to hospital (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Under the new service the practice identified the top two per cent of the adult practice population, (90 patients) with the most complex needs (81 of these were older people). These patients had a

proactive and personalised care management plan of care and support, tailored to the needs and preferences of the patient and their family. The practice reviewed the information from hospital admissions and used codes to mark patients' records so that they could be identified and offered additional support to reduce future admissions. Patients with care plans were contacted within three working days of a hospital discharge or an accident and emergency attendance to review changes and help ensure a safe and effective discharge.

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

Management, monitoring and improving outcomes for people

There was some auditing. There had been an audit of patients prescribed a medicine used to treat nausea and vomiting. The audit had been undertaken following a medicine safety alert. A total of four patients had been identified. They had been contacted by the relevant GP, their treatment discussed with them, and switched to a recommended alternative. The audit was re-run a few months later and only two patients were found to be within the alert category. GPs reviewed these cases and the continued use of the medicine was appropriate.

Another audit involved an analysis of the use of GPs and nurses time in minor surgery. A number of recommendations were made, discussed at staff meetings and implemented. There was a re-audit planned to follow in six months.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice regularly reviewed its QOF outcomes. It had not been satisfied that it was providing sufficient reviews of patients with long-term conditions. It had therefore instituted a more robust recall system for patients who needed to have an annual review. It had also increased the size of the nursing team with the addition of a health care assistant to release more time for

Are services effective?

(for example, treatment is effective)

the practice nurses to carry out annual reviews. This had resulted in improved provisions for patients. For example the percentage of patients in the practice with COPD who had had a review, in the preceding 12 months was 96 per cent, up 2 per cent from the previous year and 8 per cent better than the average locally. Similarly the percentage of patients with diabetes, seen within the last year was 94 per cent some 7 per cent higher than locally.

There was a protocol for repeat prescribing which followed national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. Patients were called have their blood taken about two weeks before the review with the practice nurse, or GP, so that the person reviewing the patient had all the necessary information.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register. It held monthly multi-disciplinary (MDT) meetings with the community nurses, complex conditions nurse, hospice nurses, and the health and social care coordinator to work collaboratively to provide coordinated holistic care to patients with complex needs and patients of concern. Individual needs and preferences, including personal, cultural, religious and social needs and circumstances were taken into consideration when making on-going care arrangements. At these meetings the practice also liaised with the complex care nurse to discuss and plan the joint management of more complex long-term conditions and to respond to the changing needs of these patients.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records. There was an overall training plan. 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. Staff had completed fire safety training.

We noted a good skill mix with GPs having qualifications in surgery and geriatric medicine. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. (Every GP is

appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager. Staff also told us that they could approach the management about identified training needs at any time. Recent training included a bespoke training package for healthcare assistants and, for administrative staff a National Vocational Qualification at level two. Training was often provided by other qualified staff within the practice although the practice was quite willing to pay for external training if it was necessary.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Results were received throughout the day and were frequently checked. The GPs who saw the documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

The GPs and nurses had access to an online database to access referral pro-formas and to identify other providers of secondary services. Referrals were usually discussed with the patient and a letter then dictated to be typed by the medical secretary. There were systems to ensure that the referrals were followed up. Where there had been a breakdown in the system the practice had investigated and had acted to reduce the risk of this happening again.

The practice used clinically recognised risk stratification tools to identify patients with complex needs to help to ensure that there were multi-disciplinary care plans documented in their case notes. The practice had developed their own tools when the enhanced service first started, as there were no standard tools and the practice wanted to ensure that the right group of patients were

Are services effective?

(for example, treatment is effective)

identified. The care plans set reminders for patients about what they needed to work on, staff and patients set targets and discussed how to achieve them and there was information and advice on what to do in the event of deterioration in the condition. The overall objective was to help patients to remain at home.

The practice held multi-disciplinary team meetings each month to discuss the needs of patients with complex conditions, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented.

There were two midwives attached to the practice and, being within the practice, were able to talk with the patient's preferred GP regularly. There were midwifery clinics at the practice each week. There was a GP advice line direct to a mental health consultant for issues such as medicines and assessment

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice had worked with the local social services to identify patients with a learning disability but had also carried out its own review which had identified additional patients.

Consent to care and treatment

Some GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice. Staff said that there had been no need to hold any such meetings recently.

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded. Consent was specifically

recorded for invasive procedures such as minor surgery including procedures such as joint injections. There were leaflets available to help patients understand the procedures, and consent was obtained in advance.

Patients with mental health problems and those with dementia were supported to make decisions through the use of care plans, in which they were involved. These plans showed the patient's preferences for treatment and decisions. Records showed 98% of dementia patients and 94% of mental health patients had been seen in the last year.

Health promotion and prevention

All new patients completed a questionnaire and were able to have a new patient check if they wished. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Staff told us of several instances where these checks had led to the early diagnosis of long term conditions. Patients over 75 had a named GP which helped to promote continuity of care but they could see an alternative GP if they chose or if their named GP was absent for some time.

Patients were encouraged to engage with self-help groups or education programmes such as Diabetes Education and Self-Management for Ongoing and Diagnosed (DESMOND) a national project to improve self-management of the condition for diabetics. The patient participation group (PPG) was arranging educational talks about long-term conditions.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Amongst the groups that the practice regarded as vulnerable were homeless people and the practice worked with the Street Pastors scheme, to identify and care for them. The practice kept a register of all patients with a learning disability. They were all offered an annual physical health check, with a practice nurse and a GP, using a template specifically designed for patients with learning disability. The practice nurses had received training from a specialist in learning disability to help encourage patients with learning disabilities to attend the practice and to make the checks as effective as possible. There was also a register of those who were highly dependent on drugs or alcohol and the practice worked closely with local drug and alcohol support services. The practice had long history of providing care to this group.

Are services effective?

(for example, treatment is effective)

The practice had a residential home for the elderly within their practice area. A specific GP took responsibility for the patients there. This assisted with continuity of care, particularly for those patients who could not get to the practice. In addition the GP had a weekly ward round at the home to support continuity of care for the residents.

The practice's performance for cervical smear showed that 83 per cent of women who were eligible had taken up the test. This was in line with the performance of practices nationally

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

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 and a survey of patients undertaken by the practice. We spoke with patients and read the comment cards that patients had completed. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. A number of questions in the national patient survey and the friends and family test covered the care patients received in the practice. The responses to these questions were all at or above the national averages. Patients said that it had been easy to make appointments with a GP and that often patients saw their preferred GP. Several patients commented that the reception staff were very friendly as well as efficient. They said that the GPs, nurses and healthcare assistants listened to them.

Patients completed 21 comment cards to tell us what they thought about the practice. We also spoke with five patients during our inspection. Both the comment cards and what the patients said were positive. There were no negative comments. This demonstrated that patients were satisfied with the care provided by the practice and said that their dignity and privacy were respected.

Patient confidentiality was respected. The layout of the reception area made it difficult to keep conversations confidential. However reception staff were aware of this and took time and trouble to maintain confidentiality. The reception telephone was placed away from the main desk to prevent conversations being overheard. Reception staff had recently received training which included the importance of patient confidentiality. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. There was a private area where patients could talk to staff if they wished. There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. We saw that staff always knocked and waited for a reply before entering any the rooms. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard.

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.

The practice was sensitive to confidential issues. There had been a recent incident involving an accidental breach of confidentiality. It had been thoroughly investigated and all the staff were aware of how it had happened and how to prevent it happening again.

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. The practice was rated well in these areas. Data from the national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 84% felt the same about the nurse who spoke with them. Both these results were significantly above average both locally and nationally.

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

The practice had access to translation services and there were notices in the reception areas informing patients this service was available. There was no hearing loop at the reception. Patient confidentiality made this impractical. However, it was apparent reception staff knew the patients who had hearing, or indeed sight, difficulties and took steps to help meet their needs.

Patient/carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access services, such as those related to their specific disabilities. There were notices in the patient waiting room and on the patient website which directed patients to support groups and organisations for carers. There was a protocol for staff to follow to help

Are services caring?

identify carers. However when we tried to identify carers from the patient record it was clear that this was not being implemented as comprehensively as the practice would have wished.

Patients we spoke with, some of whom were also carers, said that the practice was very supportive of carers and those needing care. For example where patients had been identified as having memory problems, staff telephoned them if they had missed an appointment to check if they were alright and to identify the reason why the appointment had been missed.

There was a structured approach to caring for patients with new diagnoses of life changing conditions such as cancer. The two weeks waiting time for access to cancer services

was carefully monitored and followed up so that, when it appeared that the patient would not receive the service in time, the practice could chase up the secondary provider concerned.

The practice had a protocol to guide staff when dealing with bereavement. There was information displayed, privately, so that staff were aware when a family had suffered bereavement. The notes of the deceased family and partner (if any) were updated so that staff were aware of the family's loss and could respond sympathetically. We had contact with one family member who had suffered bereavement. They told us that the practice had been caring and helpful during a difficult time.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered. For example, the surgery was a converted house and the consulting area was on the first floor. Access was by means of an external staircase. The practice recognised this was a serious barrier to providing equality of access for all patients. It had sought financial support from NHS England and NHS Property Services. It had drawn up plans and submitted a planning application to the local authority for a ground floor extension which would eliminate this inequality. The work was scheduled to begin before the end of March 2015.

The practice had learned from patients' feedback and surveys that the appointment system was not sufficiently responsive to patients' needs. So the practice had brought in early morning opening. When the current Care Quality Commission (CQC) inspection was announced the practice manager used the practice website to tell patients about it and to ask for their comments.

The practice had an active patient participation group (PPG). We spoke with the chair of the group. The chair reported that the practice was very supportive of the group. The practice manager and a GP partner attended the PPG meetings. The PPG had surveyed patients. One concern, identified by their survey, had been privacy in the reception area. The practice had responded by seeing patients who were coming out from consultations in a different area of reception to those going in to consultations. This gave a circular flow of patients so there was less risk of one patient overhearing confidential information from another. Other changes in response to patients' feedback included; implementing an online appointments booking system, introducing health related television to the waiting room and providing padlock facilities to patients with bicycles and pushchairs.

Tackling inequity and promoting equality

There were difficulties in patients with disabilities accessing the practice and the practice was addressing them through its planned expansion. At the time of the

inspection there was a chair lift from the ground to first floor and staff physically helped those who needed it to use this facility. There were toilets for the use of disabled patients and baby changing facilities.

There was a register of patients who had illnesses which made them particularly vulnerable, for example a learning disability, dementia or end of life care. When staff accessed the notes of such patients a message was displayed on the computer screen to inform the staff member of the diagnosis. Thus 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, memory or understanding.

We spoke with one person who was the carer for a patient with a severe disability. We were told that staff always made that patient welcome and that the care and treatment that person received was very much a personal care plan.

Access to the service

Primary medical services were provided Monday to Friday between the hours of 8.30am and 6.30pm. There were early morning surgeries from 6.30am to 8am twice a week. This was for appointments only and was designed to cater for patients who found it difficult to get to the practice during normal working hours. Some influenza clinics were held on Saturday mornings to improve accessibility for the same reason. There was a duty doctor available throughout the day including at lunchtimes. Though other staff did not see patients at lunchtimes the doors were not closed and patients could come in emergencies. The switchboard was closed during lunchtime but again, if the matter was urgent patients had the option to press a number and the call would be answered.

Patients were allocated a GP and their appointments were with this GP unless urgent or the GP was unavailable for some time, such as on leave. There were pre-bookable appointments, up to several weeks in advance, and appointments available on the day. There were telephone consultations available, on the day, for patients where this was appropriate. Older people requiring urgent care were seen on that day either as an emergency appointment or in a home visit if the person was housebound, in a care home or too unwell to attend. Children who called with urgent matters were seen as soon as possible and, in any event, on the day they called.

Are services responsive to people's needs?

(for example, to feedback?)

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. There were also arrangements for patients to receive urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. There was a range of standard longer appointments. For example patients with a single long-term condition received a 10 minute appointment with a nurse and those with two long-term conditions a 20 minute appointment. Nurses conducted reviews at patients' homes (or nursing homes) when this was necessary. There was a monthly memory clinic at the practice so that patients could be seen in a familiar setting, this was specifically for dementia assessment and follow up.

Other patients, such as those with mental health problems could ask for longer appointments. We heard reception staff booking these appointments and they accommodated patients needs were at all possible. Patients who had a care plan had priority in the allocation of appointments and the computer system alerted reception staff to these patients when appointments were made. Mother and baby checks were booked at eight weeks after the birth as a double appointment, first with the GP and then the nurse for the baby's first immunisations, to encourage uptake and minimise the number of appointments for new families.

Patients we spoke with were generally satisfied with the appointments system. These patients and the comment cards showed that patients felt that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often

been able to make appointments on the day of contacting the practice. For example, we heard a patient telephone reception in the late morning for an appointment and receive one in the late afternoon of that day.

Listening and learning from concerns and complaints

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

We looked at the record of complaints. The complaints were broken down into themes such as communication/ attitude, general administration, clinical issues, prescriptions and such like. This allowed the practice to monitor specific areas and learn from them. Using this approach the practice reviewed complaints annually to detect themes or trends.

Records showed how complaints had been handled and how the patients had been informed about the outcome. There had been learning from complaints. For example, a patient had complained about the way in which the practice had dealt with a prescription. This has resulted in an e-mail circular to all GPs to point out the error and to reduce the chances of it happening again. The patient was informed about the action taken and was satisfied with it. The minutes of staff meetings also reflected learning from complaints. Complainants were offered an apology where the circumstances warranted it. Complainants were referred to the Health and Parliamentary Ombudsman if the matter could not be resolved and a note of this made on the complaints log.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The staff we spoke with told us 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, that was being a “family” GP service. Staff said this meant; continuity of care, trying to ensure that patients saw their own (preferred) GP whenever possible, being responsive to the patients’ needs and putting care at the centre of their activity. Continuity of care was helped by the fact that all three GP partners worked full time.

There was proactive succession planning. One GP was retiring and one GP was going on maternity leave. The practice had identified and recruited suitable replacements. There was a comprehensive induction programme. All the patients directly affected, such as those with long-term conditions or over 75 who had named GPs, had been written to and the circumstances explained. Provisional dates for the refresher training of the GP, who was returning to work, had already been agreed and arrangements made with the training provider.

Governance arrangements

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

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP with responsibility for safeguarding. The staff we spoke with were clear about their own roles and responsibilities. Staff told us that the GPs had different areas of responsibility and they knew who to go to in the practice with any concerns. They also said that they could approach any of the partners or the practice manager, with any problems, even if it was not part of that individual’s remit. Staff felt valued and well supported and managers were directly involved in

supporting their development. For example, the practice manager and lead nurse completed the infection control audit jointly and together put forward the action plan to carry out the identified improvements.

The practice used the Quality and Outcomes Framework (QOF) to measure some areas of its performance. QOF performance was discussed at meetings set aside for that purpose and staff members tasked to drive improvement in different areas. Using QOF the practice became aware that its recording of depression in patients was out of line locally and nationally. On investigation it was clear that the patients’ conditions were being recorded as “low mood” rather than depression so that, technically, the incidences were being counted incorrectly, although the treatment did not change. All the staff were made aware of this and the recording practice changed so that the practice more fully represented the national picture.

The practice took part in a local peer review system with neighbouring GP practices. Recent reviews included gynaecology referrals and orthopaedic referrals. This gave the practice the opportunity to measure its service against others and identify areas for improvement both internally and for patients in the wider health economy. Areas for improvement in gynaecology included, increasing the numbers of patients who received initial treatment in primary care and the provision of new protocols for GPs. In orthopaedics, it encompassed the possibility of setting up a local knee pain clinic and including details of patients’ exercises patients in the reports to the GPs by the physiotherapists.

The practice had arrangements for identifying, recording and managing risks. These included fire, flood and damage to the building. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example there were risk assessments for hepatitis B vaccinations and the removal of “sharps” bins. The practice used clinically recognised risk stratification tools to identify patients with complex needs to help to ensure that there were multi-disciplinary care plans documented in their case notes. The practice had developed their own tools when the enhanced service first started, as there were no standard tools and the practice wanted to ensure that the right group of patients were identified.

Are services well-led?

Good 

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

Leadership, openness and transparency

Team meetings were held regularly. For example, there were clinical meeting once a month. There were nurse meetings and significant event meetings. There was a multi-disciplinary meeting involving the local hospice, social workers and health and social care coordinators each month. There was a full practice meeting with GPs, nurses and administrative staff every six weeks. The minutes showed that these were effective meetings with a structured agenda. Outcomes were recorded. For example, decisions about training or updates for staff, such as progress on changes to the building. Staff also told us about the staff social events they attended. Staff felt these events helped to break down barriers between different sections of the practice, making everyone more approachable.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example disciplinary procedures, induction policy, and recruitment, intended to support staff. There was a handbook that was available to all staff, which included sections on equality and harassment and bullying at work. The practice had a whistleblowing policy. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through a variety of means, including complaints, patients' surveys, the patient participation group and the friends and family test (an NHS wide initiative that provides an opportunity for patients to offer feedback on the services that provide their

care and treatment). There was an action plan resulting from this feedback. The main areas for action were; the provision of a patient calling system which would call patients and direct them to a room number. Staff provided one to one training for patients who experienced difficulties with the new technology such as electronic booking. Further training for reception staff.

The practice was open to suggestions from staff. One of the prescription staff suggested a more efficient workflow for handling prescription requests. It was discussed at a team meeting and was currently being trialled.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included a personal development plan. Staff were very positive about the practice commitment to development. The practice had taken on an apprentice member of the administrative staff during the previous year and staff felt this had been a useful learning opportunity for all concerned. Some staff told us about the addition responsibilities that were part of their development. There was a very low turnover of staff.

The practice manager and a GP regularly attended the local clinical commissioning group (CCG) meetings. The practice was an active member of the South West Kent health GP federation, as part of a larger group of practices collaborating to provide a greater range of services.