The Kings Family Practice

Quality Report

30-34 Magpie Hall Road
Chatham
Kent
ME4 5JY
Tel: 01634 810040
Website: www.thekingsfamilypractice.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection for The Kings Family Practice on 21 April 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. The practice was also good for providing services for older patients, patients with long term conditions, families, children and young patients, working age patients (including those recently retired and students), patients who's circumstances may make them vulnerable and patients experiencing poor mental health (including patients with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded.
- Risks to patients were assessed and well managed.
- The practice worked well with other services to provide treatment and support for patients that had a diagnosis of a mental health condition and/or substance abuse.
- 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 were able to book routine appointment s with the GP at a time that suited them. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

The practice proactively sought feedback from staff and patients, which it acted on.

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

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Clinical Excellence (NICE) and used it routinely. Patients' 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 training planned. There was evidence of appraisals and personal development plans for all staff. Staff worked with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing a caring service. 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. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice had developed a system to identify patients who had additional needs such as the homeless and patients who had a mental health diagnosis and/or substance abuse problems.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they were able 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, easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy although this was not documented. Staff could recite details about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 patients. 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 patients 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 patients, and offered home visits and rapid access appointments for those with enhanced needs. The practice had implemented named GPs to lead care and support to patients living in care or nursing homes.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff held lead roles in chronic disease management and patients at risk of hospital admissions 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 patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary 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. The practice had recognised that childhood immunisation rates for vaccinations were marginally below the local target levels and were working with Public Health England to improve on the uptake. What the practice had identified was the difficulties of reaching patients with alternative lifestyles and those who experience difficulty accessing healthcare. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. 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.

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

Summary of findings

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. Same day clinics with the medical team were provided. The practice offered appointments with the GPs, nurses and the health care assistant (HCA) from 6pm to 8pm one evening per week.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The GPs visited some vulnerable groups where accessing healthcare was difficult. The practice signposted patients on 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 during normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy five per cent of people experiencing poor mental health had received an annual physical health check. The practice had identified 100 patients with a mental health diagnosis which had been assessed and they had a personal care plan. 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.

The practice had a high registration of patients with substance misuse, supporting a “shared care” service with a local support organisation. The practice worked well with other mental health services and practitioners providing a shared approach for patient care.

Summary of findings

What people who use the service say

We spoke with three patients on the day of our inspection and reviewed seven patient comment cards. Comment cards were both positive and negative about the service patients experienced at The Kings Family Practice. Patients indicated that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. The negative comments related to the difficulty patients experienced getting through on the telephone to arrange an appointment. This was reflected in the national patient survey.

There is a survey of GP practices carried out on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 396 survey forms were sent out for The Kings Family Practice and 117 were returned. The main results from that survey were:

- Patients said that the last nurse they saw was good at explaining tests and treatment, with the practice scoring 91% which was higher than the local clinical commissioning group (CCG) average of 89% and the national average of 90%
- Patients said that they had confidence and trust in the nurse at the practice scoring 95% which was in line with the local CCG average of 98% and the national average of 97%
- Patients said that the last nurse they saw or spoke to was good at treating them with care and concern with the practice scoring 91% which was higher than the local CCG average and national average of 90%
- Patients reported that the experience of making an appointment was not so good and the practice scored 38%, which was considerably lower than the CCG average of 64% and national average of 73%
- Patients reported that they found it difficult to get through to the practice on the telephone with the practice scoring 28% which was considerably lower than the local CCG average of 64% and the national average of 73%
- The percentage of patients who indicated that they would recommend the practice to others was 41% which was considerably lower than the local CCG average of 67% and the national average of 78%
- The percentage of patients who would describe their overall experience of the surgery as good was 56% and this was considerably lower than the local CCG average of 76% and the national average of 85%

Patients indicated that they experienced difficulty getting to see or speak to their preferred GP and scored 48% which was considerably lower than the local CCG average of 57% and the national average of 60%

The Kings Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Kings Family Practice

The Kings Family Practice provides primary medical services in Chatham Kent from Monday to Friday. The practice is open between 8 am and 6 pm with extended hours between 6pm and 8pm Tuesday evenings and 8am and 11am Saturday mornings. All appointments for the extended hours must be pre-booked.

The Kings Family Practice is situated within the geographical area of NHS Medway Clinical Commissioning Group (CCG). The Kings Family Practice is responsible for providing care to 9,000 patients. The practice has a higher than average patient population of families, young children and working age patients , as well as students.

Services are delivered from:

30-34 Magpie Hall Road

Chatham

Kent

ME4 5JY

The practice has opted out of providing out-of-hours services to their own patients. There are arrangements with other providers (IC24) to deliver services to patients outside of The Kings Family Practice working hours.

Why we carried out this inspection

We inspected this service as part of our 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.

How we carried out this inspection

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 whose circumstances may make them vulnerable

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 April 2015. We reviewed information provided on the day by the practice. We spoke with three patients, six members of staff and two GPs. We spoke with a range of staff, including receptionists, the practice manager and practice nurses. We talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incorrect address for a referral service. As a result the practice implemented a system where verification of referral details, including the recipient, must be completed before the referral was sent. Staff were given protected time to complete this task.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over the two years and so could show evidence of a safe track record. One of the GPs and the practice manager shared the responsibility of monitoring significant events at the practice

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of five significant events that had occurred during the last 12 months and saw that the system had been followed appropriately. Significant events were a standing item on the practice meeting agenda and there was evidence that the practice had learned from these and that the findings had been shared with relevant staff or outside organisations where necessary. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff provided information about the system they used to record, manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, where medicines had been prescribed at an incorrect dose. This had been rectified and monitored since to reduce the risk of such an event happening again. Where patients had been affected by something that had gone wrong, n line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at monthly staff meetings and informally on a day to day basis to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (level three). All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example staff described how patients were "flagged" when their records were accessed. The flags enabled staff to respond appropriately or alert the GPs when new information was added.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and healthcare professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, the

appointment would be scheduled when one of the nurses or the health care assistant was available to support a patient. All staff undertaking chaperone duties had received a Disclosure and Barring Service check (DBS).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

There were processes to check that medicines were within their expiry date and suitable for use by a central stock taking system. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, medicines optimisation, and changes to generic medicines.

The nurses and the health care assistant administered vaccines using Patient Group Directives (PGDs) that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of the directions and evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a Patient Specific Direction (PSD) from the prescriber.

There was a system for the management of high risk medicines (medicines that require extra checks and special storage arrangements because of their potential for misuse) which included regular monitoring in line with national guidance. Staff were aware of how to raise concerns around high risk medicines with the controlled medicines accountable officer for their area.

We saw a positive culture in the practice for reporting and learning from prescribing incidents and errors. Incidents had been logged and reviewed promptly. Learning had taken place to reduce the risk of similar errors occurring again.

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.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The practice had a schedule of testing the equipment it used. We saw evidence of calibration of relevant equipment; for example weighing scales and the sphygmomanometer (a device used to measure blood pressure).

Staffing and recruitment

The practice had recently reviewed and updated its recruitment policy. This policy set out the standards the practice followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We noted that information with regard to clinical staff's immunity status was kept with their employment records.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risk assessments had been carried out and where risks had been identified this had been assessed, recorded and action taken to reduce and manage the risk. There were specific health and safety items discussed at practice meetings. For example, fire safety, confidential waste and data protection had all been discussed and learning needs planned as a result.

Staff could demonstrate they were able to identify and respond to changing risks to patients including deteriorating health and medical emergencies. For example, patients who were of concern or potential concern were "flagged" on their clinical records. Care plans were shared with external health providers such as the mental health team, the hospital and the out of hours service.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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. There were also processes to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a business continuity plan to deal with a range of emergencies that might impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the water company should

Good

Are services safe?

there be a problem with the water supply. Staff informed us that copies of the contingency plan were held off site by the partners and practice manager and these documents were reviewed and updated annually.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from the local clinical commissioning group (CCG). Staff could access this guidance through the practice computer system in any of the clinical and consulting rooms. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with demonstrated a good knowledge of NICE and local guidance. Staff described how they had carried out comprehensive assessments of individual patients which covered all of their health needs which reflected national and local guidelines. Care was planned to meet identified needs and patients had been reviewed at required intervals to ensure that their treatment and care remained effective. For example, patients with diabetes, heart disease, mental illness and chronic kidney disease were having regular health checks and were being referred to other services when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice told us they had commenced providing the "avoiding unplanned admissions" enhanced service in 2014. The practice used computer document tools to identify and plan the continuity of care for patients who were at risk of admission to hospital. These patients were reviewed regularly to ensure their needs were being met. Patients who were perceived as being at risk and who contacted the practice were either booked for a same day consultation or put through to the duty GP. Equally the practice had a system to review and follow up on all patient admissions and discharges from hospital on a weekly basis.

All GPs we spoke with used national standards for the referral of patients with suspected cancers and the patients were seen within two weeks. We saw minutes from meetings where elective and urgent referrals were reviewed, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Information about patients care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical monitoring to check that targets were met and to determine if more detailed audits would be required.

The practice showed us five clinical audits that had been undertaken in the last two years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit such as the prescribing of certain types of medicines used to clot blood. The outcome of this audit was to implement systems to ensure that patients records were flagged to alert the clinician to carry out checks /end treatment in a timely way

The practice also used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The practice particularly used information from both schemes to assess that they were meeting patients' needs for long term health conditions

Good

Are services effective?

(for example, treatment is effective)

such as diabetes, stroke and chronic heart disease. For example, the practice had looked at the uptake for seasonal influenza vaccines and had improved from 95% to 99% of patients with these conditions receiving the vaccine.

The practice was aware of all of the areas where there were gaps in performance compared to national or local CCG figures. We saw that achieving these targets, such as improving telephone access for patients had been discussed at whole practice meetings and that there were plans to address each gap.

The practice was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of GPs and nurses. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with 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. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. Where there were gaps this was because they were still undergoing induction or the training was already booked. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which plans for personal development were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, mental capacity assessment.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and dementia. Those with extended roles which included seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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. Out of hours reports, 111 reports and pathology results were all seen and actioned by a GP the day they were received. A buddy system was implemented to cover each GP if they were not on duty. We saw from the minutes of daily clinical meetings example of how joint working with other services had assisted the decision making around some patients care.

The practice held multi-disciplinary team meetings quarterly to discuss patients with complex needs. For example, patients with a mental health diagnosis, patients with multiple long term conditions and those in receipt of end of life care. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care

record. This included regular working with a local organisation which is part of a national health and social care provider, to support patients with substance misuse. Care plans for patients with complex needs were shared with other health and social care professionals as appropriate.

Information sharing

The practice had protocols for sharing information about patients with other service providers. Staff were knowledgeable about the protocols and patient information was shared with other service providers appropriately. For example, there was a system to monitor patients who accessed palliative care services that also helped to ensure their care plans were up to date.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hours provider (IC24) to enable patient data to be shared in a secure and timely manner.

GPs told us they discussed with individual patients and carers, which consultant to refer them to based on the patients' needs and individual preferences. GPs said they only occasionally used the 'choose and book' (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) method for referrals. They told us they tended to refer patients locally, as this was what most patients preferred. Referrals to one of the London hospitals were made if requested by the patient or their carer.

The practice had systems to provide staff with information about patients that they needed. There was an electronic patient record system used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future reference and in planning on-going care and treatment.

Consent to care and treatment

The practice had procedures for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments. For example, joint injections. There was space on the form to indicate where a patient's carer or parent/guardian had signed on the patients behalf.

GPs told us how patients who lacked capacity to make decisions and give consent to treatment were monitored and assessed. They said mental capacity assessments were carried out by them (GPs) and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support. There were procedures that helped ensure patients who lacked capacity were appropriately assessed and referred where applicable.

GPs described the process for gaining consent from patients who were under 16 years of age and stated that they followed relevant guidance, demonstrating an understanding of the 'Gillick' competencies. (Guidance which helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The practice displayed information in relation to an advocacy service in the patient waiting area, with contact details for patients and/or their carers who required independent support.

Staff were aware of the Mental Capacity Act 2005, and confirmed that elements of the legislation were also included in the training that they received. We spoke with GPs who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted that the GPs used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients were followed up within two to three weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 100% had received a physical check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 79.8%, which was in line others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend in the required timeframes. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was below average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

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 171 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's GPs. The evidence from these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated below average for patients in comparison to local and national data.

- The practice was below average for some of its satisfaction scores on consultations with doctors with 71% of practice respondents saying the GP was good at listening to them, compared to the local CCG average of 81% and the national average of 89%.
- Seventy four per cent of patients who responded said that the GP gave them enough time. Compared to the local CCG average of 81% and the national average of 89%
- The practice was in line with the satisfaction scores on consultations with the nurses with 89% of practice respondents saying the nurse was good at listening to them, compared to the local CCG average of 91% and the national average of 91%
- Patients said that the nurses gave them enough time scoring 90% which was in line with the local CCG average of 91% and a national average of 91%

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and the majority were positive about the service experienced. Two comment cards were not so positive with difficulty getting through on the telephone the reason for their comments. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence, from the minutes of staff meetings, of learning taking place.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded negatively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice below average in these areas. For example, data from the national patient survey showed 61% of practice respondents said the GP involved them in care decisions, compared to the local CCG average of 72% and national average of 81%. Also 69% of patients had responded that the GP was good at explaining treatment and results, compared to the local CCG average of 79% and the national average of 86%. The practice was aware, and working on ways to improve this.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Good

Are services caring?

they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language and for those that required an interpreter for sign language. We saw notices in the reception areas informing patients these services were available.

Patient/carer support to cope emotionally with care and treatment

The information from patients showed they were positive about the emotional support provided by the practice staff and told us that they found the staff to be supportive and very caring. This was reflected in comments from health and social care professionals who provided feedback about their observations. The practice told us they offered longer appointments for patients who needed them to aid communication. They also told us they always tried to check with patients that the gender of GP met their choices and they aimed to provide continuity of care by providing a named GP.

Notices in the patient waiting room and on the practice website, also told patients' how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the printable information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice worked with the NHS area team and clinical commissioning group (CCG) to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage the challenges of its patient population, such as support for patients with substance misuse.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice was in the process of having extra telephone lines installed. This was as a direct result of patients commenting that they experienced difficulty getting through on the telephones when the practice opened. They had also added extra staff to the rota to receive calls during their busiest times.

Tackling inequity and promoting equality

The practice had recognised they needed to support people of different groups in the planning and delivery of its services. The PPG were actively seeking to recruit people from different population groups to be involved and the practice was supporting them. GPs and other staff were involved with providing support and information to vulnerable groups such as the travellers that visit the area and patients with no fixed abode.

The practice had access to online telephone translation services and could arrange for a sign language translator on request.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals.

The premises and services had been adapted to meet the needs of patients with disabilities such as wide corridors and level access. The desk at reception had a lowered area to accommodate patients in wheelchairs.

The practice was situated on the first floor of the building with all services for patients on the first floor and administration offices upstairs The practice had wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a majority population of English speaking patients though it could cater for different languages through translation services.

Access to the service

Appointments were available from 8am to 6pm on weekdays with extended hours from 6pm to 8pm on Tuesday evenings and 8am to 11am Saturday mornings. Appointments during the extended hours were pre-booked. Patients could either call on the day they required an appointment, book online or book up to one month in advance.

Information was available to patients about appointments in the patient information pack and on the practice website. This included how to arrange routine, urgent appointments and home visits. 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, 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 also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. One of the GPs and nurses often accommodated patents who wished to be seen outside of the surgery hours, such as earlier or later, this was carried out when patients' requested to accommodate their wishes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system apart from the difficulty of getting through on the telephone when the practice opened in the mornings. Patients we spoke with confirmed that they could see a doctor on the same day if they needed to and 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 same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment for a relative; they called the practice and were seen by a GP the same day.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system such as posters displayed, a summary leaflet available in the patient information pack, on the practice website and on request from reception. Two of the 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.

We looked at the complaints received in the last 12 months and found that staff were able to describe how they responded to any complaint made and how they followed their complaints policy and records we viewed confirmed this. The practice could demonstrate that they had learned from some of the complaints they had received and some were still on-going.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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 statement to deliver a high level of evidence based holistic medical care with a Christian ethos within a safe and supportive environment. Their prime objective was to provide care for the whole person whatever their health problem, maximise the health of the local population through prevention, education and intervention. When we spoke with the GPs, practice nurses and members of the administration team, they all understood the vision and values of the practice and the aim of the practice team to achieve good outcomes for patients and the community.

Governance arrangements

The practice had a number of policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and most staff had signed a cover sheet to confirm that they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

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 the senior GP was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit was carried out to identify the number of inadequate test results so that patients could be recalled. This was a rolling programme and carried out on a monthly basis.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as an area of damp in the building, fire safety and poor lighting in the car park. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

Practice staff met bi-monthly to discuss the service delivery within their own peer groups and as a team. Important information was disseminated between these meetings should urgent issues arise. 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.

The practice employed a practice manager who oversaw the administration and management of the partnership. Their role included being responsible for human resource policies and procedures and their implementation. We reviewed a number of policies, such as those for aspects of health and safety found they were up to date and had the required information. We were told they were in the process of implementing a new resource for policies and procedures to ensure they kept them up to date and current to the changes in legislation and guidance. Staff we spoke with knew where to find these policies if required

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

The practice had gathered feedback from patients although not recently, through patient surveys, compliments and complaints received. We looked at the results of the national patient survey and saw that patients had highlighted a range of issues that they thought could be improved or what the practice did well. The practice had a patient participation group (PPG) that were in the process of implementing a patient survey. We spoke with two representatives of the PPG who told us about their involvement with the practice and the plans they had for developing the relationship and support to the practice patients. They provided information of how the practice had listened and responded to the questions they raised.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff confirmed that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were provided with opportunities to develop new skills and extend their roles.

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