# Sydenham House Medical Centre

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

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

We carried out an announced comprehensive inspection at Sydenham House Medical Centre on 2 November 2016. Overall the practice is rated as requires improvement.

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. However, reviews and investigations were not always thorough enough.
- Risks to patients were assessed and well managed, with the exception of those relating to infection control.
- Data showed patient outcomes were low compared to the national average. Although some audits had been carried out, we saw no evidence that audits were used in order to support quality improvement activity.
- The majority of patients said they were treated with compassion, dignity and respect.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Information about services and how to complain was available and easy to understand. However, there was no evidence to show that improvements were made to the quality of care as a result of complaints and concerns nor that lessons were learnt and shared to prevent instances of a similar nature occurring again.
- Patients said they did not find it easy to make an appointment with a named GP and there was no continuity of care, but 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.

# Summary of findings

- Systems and processes to govern activity were not always effective. In that they had failed to identify that not all staff had received safeguarding training at the relevant level for their role.
- Systems and processes to govern activity were not always effective. In that they had failed to identify infection control and prevention issues, the lack of clinical audit and that complaints and significant events were not always monitored and recorded appropriately.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Ensure that significant events are investigated and discussed thoroughly, actions taken and lessons learnt and disseminated, and to ensure that the accuracy of recording of significant events and complaints is stronger.
- Ensure clinical audits and re-audits are carried out to improve patient outcomes.
- Ensure that systems to routinely check the equipment used in emergencies is safe, within its expiry date and fit for purpose.
- Ensure that systems and processes to govern activity are effective and identify all areas of risk.

In addition the provider should:

- Continue to ensure recruitment arrangements include all necessary employment checks for all staff. Including appropriate Disclosure and Barring Service (DBS) checks.
- Continue to ensure they act upon patient feedback with regard to access to services.
- Revise the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if required.
- Continue to ensure that action is taken to address the areas of concern identified in respect of infection control in accordance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

**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?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services, as there are areas where improvements should be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong reviews and investigations were not always thorough and lessons learned were not communicated widely enough to support improvement.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, oxygen used for medical emergencies was not always routinely checked and children's defibrillator pads were not available. Additionally, appropriate action had not always been undertaken to address areas of concern in respect of infection control and prevention.
- There were systems to keep patients safeguarded from harm. However, not all staff had received training at an appropriate level.
- Not all the appropriate recruitment checks had been undertaken prior to employment.

**Are services effective?**

**Requires improvement**

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average
- There was no evidence of two cycle clinical audits, in order to support quality improvement activity.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services.

# Summary of findings

- Data from the National GP Patient Surveys published in in July 2016 showed patients rated the practice lower than others for some aspects of care. For example, 43% of patients gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?' Which is worse than the clinical commissioning group (CCG) average of 70% and the national average of 73%.
- Patients said they were treated with compassion, dignity and respect.
- Information for patients about the services available was easy to understand and accessible.

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

**Requires improvement**

The practice is rated as requires improvement for providing responsive services, as there are areas where improvements should be made.

Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group to secure improvements to services where these were identified. For example, outpatient clinics were held within the practice.

- Data from the National GP Patient Surveys published in in July 2016 reported that access to a named GP and continuity of care was not always available in a timely manner, although urgent appointments were usually available the same day. Patients rated the practice lower than others for some aspects of care. For example, 9% of patients stated that they always or almost always see or speak to the GP they prefer which was worse than the CCG average of 34% and national average of 35%.
- Patients could get information about how to complain in a format they could understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

**Are services well-led?**

**Requires improvement**

The practice is rated as requires improvement for being well-led, as there are areas where improvements should be made.

- The practice had a vision and a strategy and all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and staff felt supported by management.
- The practice had a number of policies and procedures to govern activity.

# Summary of findings

- The practice did not have an on-going programme of clinical audits to monitor quality and systems to identify where improvements could be made.
- The practice had systems for notifiable safety incidents however, they did not ensure this information was shared with staff to ensure appropriate action was taken.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.

# 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**

Requires improvement

The practice is rated as requires improvement for providing safe, effective, responsive and well-led services and rated good for providing caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

**People with long term conditions**

Requires improvement

The practice is rated as requires improvement for providing safe, effective, responsive and well-led services and rated good for providing caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators were comparable to the local and national average. For example, 70% of patients with diabetes, on the register, in whom the last IFCCHbA1c is 64 mmol/mol (a blood test to check blood sugar levels) or less in the preceding 12 months (local average 80% and national average 78%).

  Longer appointments and home visits were available when needed. However, not all these patients had a named GP, a personalised care plan or structured annual review to check that their health and care needs were being met.

**Families, children and young people**

Requires improvement

The practice is rated as requires improvement for providing safe, effective, responsive and well-led services and rated good for providing caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

# Summary of findings

- 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG average of 82% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

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

Requires improvement

The practice is rated as requires improvement for providing safe, effective, responsive and well-led services and rated good for providing caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, the practice was open 8am to 2pm on Saturday (for pre booked appointments only).

**People whose circumstances may make them vulnerable**

Requires improvement

The practice is rated as requires improvement for providing safe, effective, responsive and well-led services and rated good for providing caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

# Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Requires improvement

The practice is rated as requires improvement for providing safe, effective, responsive and well-led services and rated good for providing caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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  Performance for mental health related indicators were higher than the local and national average. For example, 90% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (local average 86% and national average 88%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and sixty three survey forms were distributed and 108 were returned. This represented less than 1% of the practice's patient list.

- 43% of patients gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?' Which is worse than CCG average of 70% and the national average of 73%.
- 68% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 76% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 67% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

Since our inspection and prior to publication of this report, the practice sent us an action plan on 7 November 2016 to show that they were taking action regarding improvements to the current telephone system, as well as adapting their booking system to allow patients better access.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards of which were generally positive about the standard of care received. General themes that ran through the comments included the very caring attitude of all staff and the efficiency with which the service was run. Five of the cards had negative comments about the appointment system.

We spoke with six patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, they also made negative comments about the appointment system.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure that significant events are investigated and discussed thoroughly, actions taken and lessons learnt and disseminated, and to ensure that the accuracy of recording of significant events and complaints is stronger.
- Ensure clinical audits and re-audits are carried out to improve patient outcomes.
- Ensure that systems to routinely check the equipment used in emergencies is safe, within its expiry date and fit for purpose.
- Ensure that systems and processes to govern activity are effective and identify all areas of risk.

**Action the service SHOULD take to improve**

- Continue to ensure recruitment arrangements include all necessary employment checks for all staff. Including appropriate Disclosure and Barring Service (DBS) checks.
- Continue to ensure they act upon patient feedback with regard to access to services.
- Revise the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if required.
- Continue to ensure that action is taken to address the areas of concern identified in respect of infection control in accordance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

# Sydenham House Medical Centre

**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 adviser and a practice manager specialist adviser.

## Background to Sydenham House Medical Centre

Sydenham House Medical Centre offers general medical services to people living and working in Ashford and the surrounding areas. There are approximately 15,000 patients on the practice list. The practice population has a higher than average proportion of patients with a long standing health condition. They also have a higher than average percentage of unemployment and higher than average single parent families with higher income deprivation affecting children. The practice is placed in the fifth most deprived decile. The practice building is arranged over two storeys, with all the patient accessible areas being located on the ground floor. There is easy parking and full disabled access.

The practice is similar across the board to the national averages for each population group. For example, 20% of patients are aged 0 -14 years of age compared to the clinical commissioning group and national average of 17%. Scores were similar for patients aged under 18 years of age and those aged 65, 75 and 85 years and over. The practice is located near Ashford town centre, Kent, where there are areas of deprivation and has a 90% White British population, with small percentages of Asian/Asian British and Black/Black British.

The practice holds a General Medical Service contract and consists of two partner GPs (both male) and seven salaried GPs (five female and two male). The GPs are supported by a practice manager, a clinical nurse manager/nurse prescriber, five practice nurses (female), five health care assistants (four female and one male), a phlebotomist (female) and an administrative team. A wide range of services and clinics are offered by the practice including asthma and diabetes.

The practice is a training practice which takes foundation year two and three GPs and has one trainee GP Registrar working at the practice.

Sydenham House Medical Centre is open 8.00am to 6.30pm Monday to Friday and 8am to 2pm on Saturday (for pre booked appointments only). There are arrangements with other providers (Integrated Care 24) to deliver services to patients outside of the practice's working hours.

Services are provided from:

- Sydenham House Medical Centre, Mill Court, Ashford, Kent, TN24 8DN

## Why we carried out this inspection

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. The inspection was

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 November 2016. During our visit we:

- Spoke with a range of staff (three GP partners, three salaried GPs, the clinical nurse manager, two nurses, one health care assistant, the senior management team, receptionists, administration staff) and spoke with six patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 20 comment cards where patients and members of the public shared their views and experiences of 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 were provided for specific groups of people and what good care looked 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
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

# Are services safe?

## Our findings

**Safe track record and learning**

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed.

**Overview of safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The clinical nurse manager was the infection control clinical lead. There was an infection control protocol and staff had received up to date training. The practice had an annual infection control audit undertaken in June 2016. However, it had not identified the deep cleaning or removal of stained, torn and frayed fabric seats in patient waiting areas. Since our inspection and prior to publication of this report, the practice have provided records to show that 24 new patient chairs had been ordered on 25 November 2016.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed six personnel files and found that not all the appropriate recruitment checks had been undertaken prior to employment. For example, references and the appropriate checks through the Disclosure and Barring Service (DBS). Since our inspection and prior to publication of this report, the practice have provided records to show that references had been obtained and DBS checks had been applied for on 4 November 2016 and were in progress

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Requires improvement

# Are services safe?

- Arrangements for the planning and monitoring of the number of staff and mix of staff needed to meet patients' needs. There was a rota system for all the different staffing groups to ensure enough staff were on duty.

**Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- A first aid kit and accident book were available.

The practice had a defibrillator available on the premises and oxygen. We found defibrillator pads to be used during a medical emergency for adults but there were no defibrillator pads for children. We also saw that the oxygen had not been checked for a period of two weeks, as the designated member of staff who usually checked the oxygen was on annual leave. We raised this with the practice manager. Since our inspection and prior to publication of this report, the practice have provided records to show that children's defibrillator pads had been ordered on 7 November 2016 and that a letter had been circulated by the practice nurse manager to all nurses that had duties that included checking equipment such as oxygen, to ensure that they delegated a colleague to these jobs when they were away on leave or absent for any reason.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available with 9% exception reporting (compared to the clinical commissioning group (CCG) average of 8% and the national average of 9%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators were comparable to the local and national average. For example, 70% of patients with diabetes, on the register, in whom the last IFCCHbA1c is 64 mmol/mol (a blood test to check blood sugar levels) or less in the preceding 12 months (local average 80% and national average 78%).
- Performance for mental health related indicators were higher than the local and national average. For example, 90% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (local average 86% and national average 88%).

There were several areas where the exception rate was either lower or much higher in comparison to the CCG and national averages. For example, the exception rates for:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that included an assessment of asthma control 1.2% (19 exceptions) compared to the CCG average of 7% and the national average of 7%.
- The percentage of patients with chronic obstructive pulmonary disease (COPD ) who had a review undertaken including an assessment of breathlessness 31% (87 exceptions) compared to the CCG average of 14% and the national average of 11%.

We spoke with staff who told us that there were systems to follow up patients who had not attended for their annual review. For example, patients with COPD were sent three letters and then received a telephone call. Staff told us that most of these patients were attending specialist clinics at the local NHS hospital and therefore, felt they were being reviewed on a regular basis and did not feel the need to attend the practice. Nursing staff showed us that there was a QOF box on the computer system. They told us that when a patient attended they would take the opportunity to review them and where patients had been identified as having not attended for their annual review, nursing staff encouraged them to make an appointment while they were there.

- The practice participated in medicine management audits with the support of the local CCG pharmacy teams. For example, antibiotic prescribing compliance against locally adapted primary care antimicrobial treatment guidelines for sore throats.
- Information about patients' outcomes was used to make improvements such as: reviewing patients on a certain medicine which had adverse cardiac (heart) side effects.
- However, there was no system to routinely conduct additional clinical audits and no two cycle audits had been carried out in the last two years.

**Effective staffing**

Requires improvement

# Are services effective?

## (for example, treatment is effective)

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety awareness, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Practice nurses also had training in asthma, diabetes, insulin initiation, chronic obstructive pulmonary disease (COPD) and international normalised ratio (INR) management (a measure of how much longer it takes the blood to clot when oral anticoagulation (medicines that help prevent blood clots) were used).
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. For example, by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice was a training practice which takes foundation year two and three registrar GPs and had one GP registrar working at the practice. The practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

**Consent to care and treatment**

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and having a sensitive bladder. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG average of 82% and the national average of 82%. There was a policy to offer telephone and written reminders for patients who did not attend for their cervical screening test. The practice

Requires improvement

# Are services effective?

## (for example, treatment is effective)

demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability. There were systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice achieved comparable results in relation to its patients attending national screening programmes for bowel and breast cancer screening. For example, 56% of eligible patients had been screened for bowel cancer, which was in line with the CCG average of 60% and the national average of 58%. Seventy percent of eligible patients had been screened for breast cancer, which was comparable to the CCG average of 72% and the national average of 72%.

Childhood immunisation rates for the vaccines given were comparable to CCG. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 54% to 97% (CCG average 50% to 94%) and five year olds from 89% to 98% (CCG average 89% to 98%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 20 patient Care Quality Commission comment cards we received were positive about the standard of care received. Patients said they felt the practice staff were helpful, caring and treated them with dignity and respect.

We spoke with five members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice results were comparable to the clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 75% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 87% of patients said the GP was good at listening to them compared to the CCG average of 88% and the national average of 87%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 79% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

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

Patients told us they felt involved in decision making about the care and treatment 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 available to them. Patient feedback from the 20 comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey published July 2016 showed patients responded encouragingly to questions about their involvement in planning and making decisions about their care and treatment. Results were lower than local and national averages. For example:

- 79% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 81%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

**Patient and carer support to cope emotionally with care and treatment**

Good

# Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 121 patients as carers (0.9%) less than 1% of the practice list. Written information was available to direct carers to the various avenues of support available to them. The practice's website had a 'Carers Direct' link that highlighted the various avenues for information and support groups available.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a 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.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice 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. For example, outpatient clinics were held within the practice.

- The practice offered pre-booked appointments only on Saturday from 8am to 2pm for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

Outpatient clinics were held within the practice. There were Consultant led clinics for Orthopeadics and Dermatology. In addition the practice provided diagnostic services by way of non-obstetric ultrasound, audiology hearing assessment and aid fitting as well as a GP led Dermatology clinic and Musculoskeletal clinical assessment clinic/Pain clinic.Antenatal clinics are held jointly by the doctors and midwife.

**Access to the service**

The practice was open between 8.00am to 6.30pm Monday to Friday and 8am to 2pm on Saturday (for pre booked appointments only). There were arrangements with other providers (Integrated Care 24) to deliver services to patients outside of the practice's working hours.

In addition appointments that could be booked up to six weeks in advance, as well as urgent appointments, were also available for people that needed them.

Results from the national GP patient survey published July 2016 showed that patient's satisfaction with how they could access care and treatment was below the local and national averages.

- 72% of patients were satisfied with the practice's opening hours compared to the national average of 79%.
- 43% of patients gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?' Which was worse than the CCG average of 70% and the national average of 73%.

However, when asked the question regarding seeing or speaking to a GP they preferred, the practice scored much lower than the CCG average:

- 9% of patients stated that they always or almost always see or speak to the GP they prefer which was worse than the CCG average of 34% and the national average of 35%.

People told us on the day of the inspection that they were not always able to get appointments when they needed them. Since our inspection and prior to publication of this report, the practice sent us an action plan on 7 November 2016 to show that they were having discussions with their telephone provider regarding improvements to the current system, with a view to increasing the number of telephone lines and/or adding automated messages to direct the patients to specific members of staff. The practice were also aware that their booking system needed adapting to allow patients better access.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had a triage service and telephone consultations. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

**Listening and learning from concerns and complaints**

The practice had an effective system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

- 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 a poster was displayed in the waiting area.
- The practice kept written records of verbal interactions as well as written correspondence.

We looked at 15 complaints received in the last six months and found they had been dealt with in a timely way.

However, there was no evidence available to show that lessons were learnt from individual concerns and complaints and from analysis of trends, as well as actions having been taken as a result to improve the quality of care. For example, we saw that there had been a breach of confidentiality when a referral had been sent to a patient's parents. Action had been taken in the form of a written apology, however, there was no evidence to show that discussion had taken place and lessons had been learnt to avoid this happening again.

# Are services well-led?

Requires improvement

(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 mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a good strategy and supporting business plans which reflected the vision and values and were regularly monitored.

**Governance arrangements**

Systems and processes to govern activity were not always effective. In that they had failed to identify; that not all the appropriate recruitment checks had been undertaken prior to employment, that not all staff had received safeguarding training at the relevant level for their role, there was a lack of emergency equipment, there were infection control and prevention issues, a lack of clinical audits , knowledge of practice performance and that complaints and significant events were not always monitored and recorded appropriately.

- Although the practice was part of a larger group of practices and most of the governance arrangements were centralised, there was a clear staffing structure that was understood by staff. Staff were aware of their own roles and responsibilities.
- Policies were group policies, copies of which were held in the practice and accessible to all staff. Policies and risk assessments that needed to be, were specific to the practice.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

- When there were unintended or unexpected safety incidents, we saw that reviews and investigations were not always thorough and lessons learned were not communicated widely enough to support quality improvement. We also saw some errors in the accuracy of the recording of significant events, as well as the detail of recording in some complaints. For example, two significant events that we looked at had unclear investigation details recorded and important details were missing such as names and dates. Additionally, there was no recording of the actions taken to address the outcome of the investigation.
- The practice participated in medicine management audits with the support of the local clinical commissioning group (CCG) pharmacy teams. However, there was no system to routinely conduct additional clinical audits and no two cycle audits had been carried out in the last two years.

**Leadership and culture**

The leadership, governance and culture did not always support the delivery of high-quality person-centred care.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

The arrangements for governance and performance management did not always operate effectively. There had been no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology. However, the recording of some significant events and complaints was not always effective. For example, errors were noted with regards to dates not being recorded and information about actions taken and lessons learnt from these incidents not always being documented appropriately.

There was a clear leadership structure and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues to their line manager to be fed into team meetings and that they felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by their line manager and partners in the practice. All staff were involved in discussions about

# Are services well-led?

Requires improvement

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

how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

**Seeking and acting on feedback from patients, the public and staff**

The practice encouraged feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the group discussed the implementation of a newsletter and also their assistance with the flu clinic campaign. We saw from minutes that the flu campaign had been gone well and senior management had conveyed their thanks to the PPG for all their help and support.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, consistently reviewing data and new care and treatment for their patients aged 75 years and over.

The practice was a training practice which took foundation year two and three registrar GPs and had one trainee GP Registrar working at the practice. All the staff were, to some degree, involved in the training of future GPs. The quality of GP registrar (GPs in training) decisions was under near constant review by their trainers. The practice was subject to scrutiny by the Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. Registrars were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. Therefore GPs' communication and clinical skills were regularly under review.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The registered providers system to routinely check the equipment used in emergencies was not safe.<br>They had failed to ensure that children's defibrillator pads used during a medical emergency were provided and that oxygen was routinely checked.<br>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• The registered person did not have robust systems to review, investigate, remedy, and learn from, incidents that affect the health, safety and welfare of people using their services.<br>• The recording of significant events and complaints were not always accurate and completed appropriately.<br>• The registered person did not always assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).<br>There was no on-going programme of clinical audits which could be used to monitor quality and systems, in order to identify where action should be taken.<br>Systems and processes to govern activity were not always effective. In that they had failed to identify; that not all staff had received safeguarding training at the |

This section is primarily information for the provider

# Requirement notices

relevant level for their role, infection control and prevention issues, the lack of clinical audit and that complaints and significant events were not always monitored and recorded appropriately.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.