Grosvenor 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.

Summary of findings

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Summary of findings

Overall summary

Grosvenor Medical Centre provides primary medical services for patients in Tunbridge Wells. The practice has seven general practitioners (GPs), six of whom form the partnership that manages the practice.

The practice has a single site at 23 Upper Grosvenor Road, Tunbridge Wells, Kent, TN1 2DX.

As part of the inspection we talked with the local Clinical Commissioning Group, the local Healthwatch, members of the Patient Participation Group, 18 patients who were at the practice on the day of the inspection, GPs, clinical staff and administrative staff at the practice. We received six responses to the comments cards that were available at the surgery during our visit, all the comments were complimentary about the care and treatment.

Patients we spoke with were very satisfied with the care and treatment they had received and told us that they felt involved in their care. The patients spoke very highly of the GPs, the nursing staff and the receptionists.

We found that there processes were in place to learn from significant events. The clinical results of the practice showed very good patient outcomes and a range of clinical audit was undertaken. We saw that GPs and staff were kind and caring. The practice had an effective patient participation group. The leadership had mechanisms to allow staff to contribute to the running of the practice.

There were services for older patients provided by the GPs and the practice nurses which met their needs. There were services for patients with long term conditions provided by the GPs and specialist clinics which met their needs. There was quality information available to them to maintain as healthy a lifestyle as possible. There was a range of clinics and services for mothers, babies, children and young patients including well woman clinics and child health clinics. Patients of working age or recently retired had services which were available to them in that there was an evening surgery one a day a week. GPs had telephone appointments for those who might not be able to attend during the standard working day. The practice regularly provided services to the homeless. There was a sustained improvement in outcomes for those with mental health problems.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. We saw that arrangements were in place to ensure safe patient care. There was an effective system in place to learn from significant events, accidents or incidents. Safeguarding procedures were in place to ensure patients were safeguarded against the risk of abuse. We found there were appropriate arrangements in place for managing medicines. The practice was clean and there were effective systems in place to minimise the risk of healthcare associated infection.

Are services effective?

The practice was effective. There was evidence of clinical audit across a range of activity. Care and treatment was delivered in line with best practice guidelines. QOF results for the practice showed that it achieved high scores in areas related to providing effective treatment for patients. Staff were aware of the importance of working with other services to achieve the best outcomes for patients. There was a wide choice of health promotion material both on paper and web based.

Are services caring?

The practice was caring. All of the patients we spoke with or who provided feedback were complimentary about the care they had received. We saw and heard staff were caring and compassionate.

Patients said that they had enough information and time with the GP or nurse to meet their needs and that treatment options were explained to them.

Are services responsive to people's needs?

The practice was responsive. There was an active and effective patient participation group. There was a clear complaints policy. Comments and complaints were acted upon to improve the practice.

Are services well-led?

The practice was well led. There was a strong structure and staff were clear about their accountabilities. There was an open and supportive culture.

There were audits and risk management tools in place to ensure patient, staff and visitor safety. There was evidence of strong clinical governance which ensured that lessons were learned and acted on

Summary of findings

at the appropriate levels within the organisation. There was a meeting structure that allowed for all staff to have a say in running the practice. The practice recognised strategic risks and had plans in place to mitigate them.

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

We found that the service was responsive to the needs of older patients. Older patients were part of the general practice population. Older patients were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. Every patient who was over 75 had an allocated GP. There were specialist clinics and information available to support patients who were over 75 with maintaining a healthy lifestyle. Clinics and advice included weight, blood pressure, diet and specifics, such as blood sugar, for those who needed it.

The practice was caring of older patients for example there was a dementia service available. GPs would visit older patients at home if they were not able to go to the surgery. There were systems in place to cater for the current demands of older patients and to recognise the future demand.

People with long-term conditions

We found that the service was effective in treating the needs of patients with chronic conditions. Patients with long term conditions were part of the general practice population. They were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. The practice offered annual flu vaccinations routinely to patients with long term conditions. There were treatment plans for some long term conditions. The plans were monitored and kept under review by multi-disciplinary teams. There were clinics specifically for the treatment of long term conditions such as asthma and diabetes. The practice was responsive to any urgent care needs that patients with long term conditions required. It was well-led in relation to improving outcomes for patients with long-term conditions.

Mothers, babies, children and young people

The practice offered dedicated clinics to patients in this population group such as midwifery clinics and a health visitor service. Mothers, babies, children and young patients were part of the general practice population. They were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. The practice was responsive and effective with one of the GP partners having a special interest in women's health We saw that referrals to other community based services were made, in

Summary of findings

order to provide these patients with additional support. The practice was well led in regard to this group as there was a nominated lead for safeguarding children. We saw that safeguarding referrals had been effectively made.

The working-age population and those recently retired

The practice was responsive to the needs of patients in this population group. The practice had extended practice hours to be available to the working age population. There were clinics such as well man clinics to support this population group. There was healthy living advice. There was an evening surgery one day a week and GPs had telephone appointments.

People in vulnerable circumstances who may have poor access to primary care

We found that the service was caring about vulnerable patients. There was disabled access, which had been specifically installed to provide access for vulnerable patients. The practice responded to the needs of the homeless and regularly had homeless patients on the GP list. There were appointments available on the day so that vulnerable patients could be seen on the day they attended the practice.

People experiencing poor mental health

There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate systems and methods of referral were in place in order to provide patients with mental health problems access to specialists, these included psychologists, counsellors and support workers. GPs in the practice had individual lists and this increased the likelihood of more continuity of care. Results of OQF assessment showed that the practice had focussed successfully on mental health issues.

Summary of findings

All of the patients that we spoke with on the day of our inspection or who completed the comment cards were very positive about the services. One patient had been with the practice for over 30 years and had had only one change of doctor during that time. Patients said that their problems were picked up and acted upon quickly. They said that they were seen within a few minutes of their appointment time. Two older patients told us that the GPs do home visits if the patients were not able to visit the practice.

Patients said that they had no concerns with regard to hygiene and the cleanliness of the practice. They told us that staff always washed their hands when examining them or carrying out a procedure. They told us that they were involved in their care and treatment and that treatment options were explained. They told us that they received enough information to be able to make their own decisions. They said that they were not hurried into making decisions.

The recent survey results (2013 GP Patient Surveys) showed that the proportion of patients using this practice who would recommend their GP practice and the percentage of patients rating their practice as good or very good was high. This placed the practice as among the best in this regard. Percentage of patients rating their ability to get through on the phone as very easy or easy and the percentage of patients rating their experience of making an appointment as good or very good were also among the best.

Grosvenor Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector, a General Practitioner, a specialist advisor in clinical governance and expert by experience. Experts by experience are people who have experience of using health or care services. During our inspections, they spend time talking to patients and observing the environment.

Background to Grosvenor Medical Centre

Grosvenor Medical Centre is a GP practice providing primary care for patients in Tunbridge Wells, Kent. It is a large practice with multiple partners and provides primary care for about 9,500 patients.

There is one surgery site: Grosvenor Medical Centre, 23 Upper Grosvenor Road, Tunbridge Wells, Kent, TN1 2DX.

There are seven doctors at the practice. The practice provides a full range of GP services. For example, there are child health, midwifery and minor operations clinics. In addition there are specialist clinics such as asthma, coronary heart disease and diabetes.

The practice is approved for training of GPs and has GP registrars working at the practice, these are qualified doctors who are training to be GPs.

The general demographics are typical of this part of the south east. For example there is a higher percentage of the practice population in the 65 and over age group than average and a higher percentage of the practice population in the 18 and younger age group.

Why we carried out this inspection

We inspected practice as part of our new inspection programme to test our approach. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients needs?
- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Mothers, babies, children and young patients
- The working-age population and those recently retired
- Patients in vulnerable circumstances who may have poor access to primary care
- Patients experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the practice. This included local population data,

Detailed findings

results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining "good practice" in their surgeries.

We asked the local Clinical Commissioning Group and the local Healthwatch to share what they knew about the practice.

The visit was announced on the practice website and patients were asked to send their comments to the CQC lead inspector whose e-mail address was provided. We placed comment cards in the surgery reception so that patients could share their views and experiences of the practice before and during and after the inspection visit.

We carried out an announced inspection on 19 May 2014. During the inspection we spoke with a range of staff. This involved General Practitioners (GPs), registered Nurses and Healthcare assistants, receptionists and administration staff including the practice manager. We spoke with patients, with carers and/or family members.

Are services safe?

Summary of findings

The practice was safe. We saw that arrangements were in place to ensure safe patient care. There was an effective system in place to learn from significant events, accidents or incidents. Safeguarding procedures were in place to ensure patients were safeguarded against the risk of abuse. We found there were appropriate arrangements in place for managing medicines. The practice was clean and there were effective systems in place to minimise the risk of healthcare associated infection.

Our findings

Safe patient care

New patients completed a health questionnaire which provided details of their medical history, their lifestyle and any current health concerns. The results were scored and those with a high score, for example in their alcohol intake, and those with long term illnesses were identified and offered a GP or nurse appointment. This was so that their individual needs could be assessed and addressed as soon as possible. Individual GPs had their own list within the practice and new patients were allocated to a named GP which led to consistency in care for the patients. Patients notes were requested from their previous GP and relevant information scanned into their electronic record.

The GPs and trainee GPs reviewed cases where they had clinical problems and discussed different ways of approaching the issues. This minimised the potential for error and allowed GPs and trainee GPs to consider whether their approaches to problems were reflecting national and professional guidance. The practice protected patients from unsafe equipment and medicines by having a process for dealing with safety alerts. For example for those medicines posing potential risk due to contamination. These were received by the practice manager who sent them on to the named lead practitioners for various areas, such as prescribing or medical devices. They were discussed at the practice business meetings which took place every other month to share the information across staff in the practice.

Learning from incidents

Staff we spoke with were aware of the significant event process and how to report them. The practice had a system to record the events. The events were collated by the practice manager and a summary was produced which was then discussed at clinical meetings. There was a similar system in place for nursing staff. Occasionally individual GPs used these summaries to complete a personal learning document which was part of that GPs appraisal process.

Safeguarding

Patients we spoke with said that they felt safe at the practice. The practice offered a chaperone option where a member of staff would be available to accompany patients during intimate examinations at their request. We saw notices in the waiting area and in consultation rooms informing patients about chaperones. There was a GP

partner lead for safeguarding who had been trained up to the appropriate level. All staff had had up to date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral. All the staff we spoke with were aware of who the safeguarding lead was and how to make a referral. Staff described a safeguarding referral which resulted in an investigation and advice given to the practice.

Monitoring safety and responding to risk

We saw a range of services available to keep patients safe and meet their needs. Staffing establishments were set and reviewed, as well as the GPs, doctors and nurses employed at the practice there were other team members attached to the practice. These included a dementia service, counsellors and a midwifery service.

The staffing levels and skill-mix was managed to support safe, effective and compassionate care. For example, staff worked flexibly to administer influenza vaccinations during busy periods. There was a GP available each day to deal with urgent appointments. The practice rarely employed locum GPs preferring to cover each other's work load during leave periods. We spoke with clinical and reception staff and saw that they were experienced in prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs.

In order to respond more flexibly and quickly to risk the practice had employed a nurse practitioner. This is a nurse who has completed advanced coursework and clinical education beyond that required of the standard nursing qualification. This nurse was able to accept a number of urgent requests for appointments and therefore the practice was better able to manage the demand.

Medicines management

We saw that there was a comprehensive policy for repeat prescribing. We spoke with a member of the clinical team who confirmed that the practice had a system for checking that repeat prescriptions were issued according to the medicine review date for each patient. All the partners had their own list of patients and they were responsible for signing their patients prescription requests daily. The only exception being when they were absent from the practice when the requests were signed by the duty GP. At the time of signing the GP checked the medical record for over or under usage of the medicine and to see if a medicines review was needed. The computer system also highlighted in red the prescriptions that were overdue for a medication review. This allowed GPs to carry out medicine reviews, opportunistically, during any consultation with the patient.

We saw that the practice had processes for maintaining the vaccine cold chain, in line with the manufacturers' recommendations so that the viability of vaccinations could be assured. A cold chain is a temperature-controlled supply chain. The vaccines were kept in a fridge and we saw that staff were routinely monitoring and recording the fridge temperature to ensure that it was operating within a safe range.

The practice had a systematic approach to medicines management, there were regular reviews and audits of prescribing practice. For example, during an audit of the use of a pain relief medicine the practice had identified that some patients might have become over dependent on it. The practice was reducing its use of the medicine.

Cleanliness and infection control

The practice had an infection control policy, which included a range of procedures and protocols for staff to follow, for example, hand hygiene, clinical waste, and personal protective equipment (PPE). We saw that these were displayed in the treatment rooms to raise staff awareness. Staff we spoke with told us about the infection control policy and their own role with regard to good infection control practices

The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with ample PPE including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for patients to use and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the building. Patients told us that the staff always washed their hands and the practice was always cleaned to a high standard. Patients told us that they had no concerns with regard to the cleanliness of the practice.

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

Are services safe?

Treatment rooms were fitted with hard flooring so spillages were easily cleared up. Sharps containers were date labelled, not over-filled and disposable. This meant that patients were treated and cared for in a clean, hygienic environment.

Staffing and recruitment

Staff were recruited safely with robust checks being carried out on all of the GPs including locums.

No checks via the Disclosure and Barring Service (DBS) had been undertaken for reception or administration staff whose duties included chaperoning. This is where a member of staff accompanies the patient during an examination or consultation. This had been risk assessed and deemed unnecessary because the staff were always accompanied by a GP during chaperoning. However there were other areas of activity such as access to confidential information, handling prescriptions and monies that were not risk assessed. The practice manager told us that this would be rectified immediately.

Dealing with Emergencies

Staff had received Cardio Pulmonary Resuscitation (CPR) and Basic Life Support (BLS) training. The duty GP was nominated to deal with emergency situations. The practice had a good supply of emergency medication however when we checked we found that some of the medication was out of date. The senior partner assured us that this would be rectified immediately. There were contingency plans for extreme events such as fire, inclement weather and loss of utilities to to reduce the impact on patients and allow the practice to continue to provide care.

Equipment

The practice had taken steps to reduce the risks associated with poorly maintained equipment. We saw evidence of appropriate maintenance of the equipment including electrical checks and calibration of clinical apparatus such as blood pressure monitors and nebulisers. All had been checked, tested and passed as fit for purpose. For example, we saw stickers on equipment showing that portable appliance testing had been carried where appropriate.

We looked at the emergency medicines and equipment available. The range available was consistent with the guidelines issued by the Resuscitation Council (UK). There was an automated external defibrillator (AED), which was routinely checked, and staff were trained in its use.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the practice was effective. There was evidence of clinical audit across a range of activity. Care and treatment was delivered in line with best practice guidelines. QOF results for the practice showed that it achieved high scores in areas related to providing effective treatment for patients. Staff were aware of the importance of working with other services to achieve the best outcomes for patients. There was a wide choice of health promotion material both on paper and web based.

Our findings

Promoting best practice

All patients had, as the minimum requirement, the opportunity for an annual review. The practice used the National Institute for Health and Care Excellence (NICE) guidance. This was incorporated into local guidelines and care pathways, these included hypertension (raised blood pressure) and minor surgery. The practice also used their own templates to enter data on to the clinical records, wich had been produced using clinical guidelines. Therefore the practice could audit a wider range of activity and examine its performance against national guidelines such as NICE guidance. Further examples of the use of guidance included a Clinical Commissioning Group (CCG) antibiotic prescribing protocol, care planning for patients with deep vein thrombosis (DVT) and protocols for the treatment of patients with lymphoedema (a long-term condition causing swelling of body tissue). This showed evidence based, assessment, care and treatment in line with recognised guidance was taking place at the practice.

The practice used the quality outcome framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining "good practice". The QOF data for this practice showed that it generally achieved high or very high scores in areas that reflected on the effectiveness of care.

Management, monitoring and improving outcomes for people

The practice used information to analyse the effectiveness of some of the treatments provided to patients and registers were kept to identify patients with specific conditions, such as patients with dementia. We saw evidence that clinical audits were undertaken. For example, there had been a recent medicines' review which had highlighted that the practice were 10% over the anticipated norm for the prescribing of food supplements compared with similar practices. This had been assessed, discussed at clinical meetings and changes to practice suggested. There was a future medicines' review planned where the effects of the changes would be monitored.

The practice had GP registrars, these are trainee GPs, working with them. Each trainee had a mentor who was a GP at the practice. Trainees' surgery sessions were

Are services effective?

(for example, treatment is effective)

co-ordinated with free space in their mentors' schedule. This allowed trainees and mentors to regularly discuss individual patients to ensure their treatments followed best practice.

Staffing

Some of the GPs had completed their revalidation (this is the process for doctors to assure the General Medical Council that they are up to date and fit to practise) and all were appraised annually. Staff we spoke to about the appraisal process said that they had found it useful. It had helped to identify training needs and provided an opportunity for staff to examine their performance. Staff appraisals were up to date and appraisal interviews were booked well in advance. This allowed staff and managers time to consider their achievements for the past year and their aspirations for the next.

We saw that there was a very comprehensive induction programme. There was a full day by day plan, followed up by active observation of the employee in post and signed off by the staff member and the manager involved

There was an overall training plan. We saw that mandatory training such as fire safety, manual handling and safeguarding had been completed by all staff. Areas of training that were considered to be most important for the safety of patients and staff had been completed. Staff had protected learning time which they could use as a group allowing them to share learning experiences. Staff we spoke with said that they were supported to undertake relevant learning. We were given examples that included non-clinical matters such as complaints and time management training. There was training in clinical matters such as diabetes and prescribing. The advanced nurse practitioner had received training support from the practice to achieve this role. Patients were cared for by staff with the clinical expertise and the practice was supported by staff with the necessary administrative skills.

Working with other services

Patients health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. There were multi-disciplinary team meetings (MDT). These were meetings that involved various professionals from outside and inside the practice for example, district nurses, social services, GPs and other specialists. These meetings involved careful consideration of the patient's conditions which included spiritual, where appropriate, as well physical matters. For example, each month there was an MDT meeting entitled risk profiling and care management. This meeting sought to identify those patients who were predicted to become or were at significant risk of emergency hospital admission. To improve the quality of care and reduce the individual's risk of emergency hospital admission the GPs worked with other multi-disciplinary professionals, to achieve a shared, integrated and personalised approach to the care of each patient.

The practice had protocols and systems in place for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. We saw evidence that the practice maintained links with community nursing teams, specialist mental health nurses, the long-term conditions nurse and the palliative care team. The palliative care meeting for example, enabled GPs to discuss the needs of patients with chronic and terminal illness, they discussed arrangements for individual patients on advanced care plans and they ensured the out of hours service was informed of the care arrangements.

Health, promotion and prevention

We were told that all new patients were offered a health check. They were given a questionnaire and offered an appointment with the practice if necessary. This gave new patients the opportunity to be assessed and to receive professional advice about their current health and lifestyle options.

There was a range of leaflets available to inform patients about health care issues. These included smoking cessation, diet and healthy living. The practice website had a number of useful links and it was easy to navigate. There was a page of information links which gave access to information such as asthma, diabetes, sexual and mental health and smoking cessation . There was a specific link for carers giving advice on how to access help.

We spoke with the nurses who conducted the various clinics. They explained how they would explain the benefits of particular lifestyles to patients with long term conditions such as diabetes. This was to ensure that patients had the knowledge to live as healthy a lifestyle as their long term conditions permitted.

Are services caring?

Summary of findings

The practice was effective. There was evidence of clinical audit across a range of activity. Care and treatment was delivered in line with best practice guidelines. QOF results for the practice showed that it achieved high scores in areas related to providing effective treatment for patients. Staff were aware of the importance of working with other services to achieve the best outcomes for patients. There was a wide choice of health promotion material both on paper and web based.

Our findings

Respect, dignity, compassion and empathy

Patients were treated with respect. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. There was a private room off the reception area where patients could talk with reception staff if necessary. Although the reception area was open plan the reception telephones were behind a free standing wall so that conversations on the telephone could not be heard by patients. We listened to the reception staff talking to patients on the telephone and in person. They were consistently pleasant and respectful to them. We heard staff asking if patients would like to see a female or male member of staff. All the patients we spoke with told us that they felt the staff at the practice treated them with respect and were polite. Patients said that staff considered their privacy and dignity and we saw notices informing patients that they could ask for a chaperone if they wished to.

Patient confidentiality was respected. Consultation rooms had examination couches with surrounding privacy curtains and blinds at the windows that were used when consultations or treatments were undertaken. We noted that during a consultation the doors were closed and no conversations could be overheard in the corridor outside. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. The staff we spoke with demonstrated how they considered patients privacy and dignity during consultations and treatments.

Involvement in decisions and consent

Patients expressed their views and were involved in making decisions about their care and treatment. Patients were given appropriate information and support regarding their care or treatment. There was a range of leaflets available in the reception area. These provided health promotion and other medical and health information for patients. In addition to general information patients were provided with information specific to their condition. When a patient received a diagnosis this was entered onto a computer system which printed information relevant to that diagnosis. This was then given to the patient.

NHS Choices is an on-line facility which allows patients to comment on their experiences on NHS services. We saw from the NHS choices website several patients from this practice had commented about their own involvement in

Are services caring?

their care. Patients felt that whist the GPs gave advice they also listened to the patients own views. The comments cards we read and patients we spoke with on the day of the inspection reinforced this view.

The practice actively ensured that there was access to information to assist patients in making decisions about their care. There was information about appointments, clinics and other services on the website. The practice website also provided links to other useful sources of information including various cancers, mental health, epilepsy and other health promotion advice. This meant that the practice was actively ensuring that there was access to information to assist patients in making decisions about their care.

There was a minor operations suite at the surgery and we spoke to the GP whose speciality this was. We saw that there was a separate protocol and consent form for minor operations. Patients were given a consent form and an information leaflet relating to their procedure. Following the procedure they were also provided with a leaflet explaining possible complications and how to deal with them. We looked at one leaflet concerning skin surgery. It covered general advice such as pain management and infection. There were more specific sections such as checking the wound dressings and follow up arrangements. Therefore in the event of complications the patient had a source of information that might help them to decide on an informed course of action. It also meant that patients and relatives were encouraged to contact the practice if necessary and speak to someone about their care.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive. There was an active and effective patient participation group. There was a clear complaints policy. Comments and complaints were acted upon to improve the practice.

Our findings

Responding to and meeting people's needs

There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. We heard reception staff offering patients the choice about being seen by a male or female member of staff. We saw that staff were caring. Staff helped patients who had mobility problems. Reception staff listened and responded to patients' needs. For example, we heard a receptionist making an appointment for a patient who required two appointments in the same week. The receptionist arranged with the patient for the two appointments, which were with different staff members, to be consecutive. This resulted in the patient spending less time at the practice and also in having a more timely investigation.

The practice actively worked to identify patients who were acting as carers for others, whether they were registered with the practice or not. They had implemented their own coding on the patient record so that they could identify carers. This allowed them to focus on carers as a group, or as individuals, to help them receive the assistance they might need. The practice had a similar system to identify vulnerable families. This was in line with recent National Institute for Health and Care Excellence (NICE) guidance.

GPs in the practice had named lists so that personalised and continuity of care could be provided. The practice already had named doctors for all patients over 75 years of age so did not need to take action in response to the recent drive to achieve this.

We looked at the process of patient referrals. Generally the GP dictated letters which were subsequently typed by medical secretaries. The practice accessed "choose and book" (the national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment). However patients made little use of it except to identify non NHS providers to whom they might be referred. There was also a locally administered database the Document Organisation, Referral and Information Service - a web- based system (DORIS) that included names and addresses of local specialists, referral proforma and informative leaflets for use during consultations. Staff could accurately and quickly make referrals and ensure that patients needs were dealt with efficiently.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients were encouraged to book routine appointments with their registered GP as this allowed for good continuity of care. Morning surgeries ran between 8.10am-10am for routine appointments and then for urgent appointments from 11 am-11.30 am. Staff told us that this half an hour slot was usually enough to see the urgent cases who could not be seen by their own GP. They told us that all the patients who needed urgent appointments would be seen on the day. This was assisted by the fact that the advanced nurse practitioner was able to see some of the urgent cases.

Patients we spoke with were very complimentary about access to the practice. Six of the 19 patients we spoke with had urgent appointments made on the day. We saw that at about 11am when the practice was very busy, including a patient who had come in having fallen over nearby, the receptionists were calm and unhurried. All of the patients were seen at the time of, or close to, their appointment. In the 2013 GP patient survey the result for the practice in this area ie making and keeping appointments was among the best. Patients could book on line or over the telephone. The practice had a number of male and female GPs so patients could choose who they wished to see. We heard receptionists offering this choice to patients.

The practice had a web based management system. which enabled them to use text messaging for patient reminders and appointments and for access to repeat prescriptions forms. Patients who needed longer appointments such as those with mental health problems could request double appointments if needed. We spoke with two elderly patients who said that GPs did home visits if patients had difficulty in coming to the practice. The practice had increased the number of surgery hours to cope with the increase in demand. In addition the GPs performed telephone triage or had telephone appointments. This was usually with the patient's named GP.

There was an evening surgery on Tuesday evenings for patients whose working schedule made it difficult to see a GP during the day, such as commuters.

There was a substantial number of transient patients who attended the practice. This was due the number of support agencies for the homeless in the area. The practice always accepted them and they were given temporary registration status. The usual pattern was that they would be seen frequently for a short period for a particular condition then they stopped attending. The premises were accessible to disabled patients with a ramp and limited disabled parking. There were baby changing facilities for parents with babies.

Concerns and complaints

We saw that the practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. The policy and procedure were based upon the recommendations of Local Medical Committee and reflected the requirements of the NHS complaints process. The practice could compare results against other practices and its own previous performance because common standards were in force.

There had been six complaints during the previous 12 months. There was a register of the complaints. The register comprised a summary, the actions taken and outcomes and learning points. The learning points were personalised when required, for example a named person being reminded of the need to preserve confidentiality when leaving telephone messages. We looked at one complaint from a relative which showed that the practice learned from complaints both in terms of individuals' practice and learning across the organisation as a whole. The complaint had been investigated and honestly answered. As a result of the complaint the practice had decided to review the process for all patients who had any form of cardiac failure as part of their history.

Are services well-led?

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

Summary of findings

The practice was well led. There was a strong structure and staff were clear about their accountabilities. There was an open and supportive culture.

There were audits and risk management tools in place to ensure patient, staff and visitor safety. There was evidence of strong clinical governance which ensured that lessons were learned and acted on at the appropriate levels within the organisation. There was a meeting structure that allowed for all staff to have a say in running the practice. The practice recognised strategic risks and had plans to mitigate them.

Our findings

Leadership and culture

The staff we spoke with told us that they felt well led and described a practice that was open and transparent. Staff consistently said that they understood what the practice stood for, for example trying to ensure that patients saw their own (preferred) GP whenever possible and trying to respond to patients needs to the best of their ability at all times. Both clinical and non-clinical staff told us that the GPs and practice manager were very approachable. We saw evidence of this when a receptionist felt able to approach a GP over a safeguarding concern. This showed that there was an open culture which had directly protected a patient. Equally this transparency meant that staff could question decisions made by others and improved the quality of the care that patients received.

There was regular discussion amongst the partners about the strategic direction of the practice. This took place during the partners' quarterly meeting where discussions such as how changes to the local population or changes to staffs' personal lives might impact on the need to recruit staff. For example, we saw how the practice had adapted to taking on an extra 800 patients because of changes in the local health economy.

Governance arrangements

There was a range of mechanisms to manage governance of the practice. Primarily this revolved around the clinical and non-clinical meetings attended by people both within and external to the practice. There was a meeting of the GPs every other week where clinical issues were discussed as well as resolving immediate matters such as covering for unexpected absences. To meet the immediate needs of patients GPs tried to get together for an informal mid-morning break and said this was often useful in resolving problems.

There was an organisational chart setting out the structure of the practice showing lines of both accountability and clinical supervision. New staff received this as part of their induction. There were other meetings specific to various functions or departments. For example, there were regular clinical meetings of both GPs and nursing staff. There was a separate meeting for reception staff. Minutes of these reflected the responsibility that the practice invested in receptionists. For example how to deal with tissue samples and deliveries for nurses were discussed in detail. The

Are services well-led?

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

meeting ended with very positive feedback from patients comments to reception staff on how helpful, polite and friendly patients found them. This showed a co-operative and supportive team based approach with teams clearly understanding their own tasks.

Trainee GPs felt that there was good governance of the practice. The mentor GPs provided regular tutorials with case analysis of both the trainee's and the trainer's patients. Trainee GPs felt that within the practice there was openness between the staff and GPs.

Systems to monitor and improve quality and improvement

The practice was a training practice and all the clinical staff were to some degree involved in the training of future GPs. This meant that the quality of GP registrar (trainee) decisions was under near constant review by their trainers. GP trainees and trainers had adjacent consulting rooms to so they could communicate more easily. As a trainer of GPs the practice was subject to scrutiny by the Health Education Kent, Surrey and Sussex (called the Deanery). Trainee GPs were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice meaning that GPs communication and clinical skills were regularly under review.

The quality of care was reflected in the practice achievements against the Quality and Outcomes Framework (QOF). The practice scored very highly in the area that measured clinical achievement, despite being unable to score points in an area where they had no applicable patients. QOF compares performance with that of surrounding practices. The practice had also reviewed their QOF performance and adjusted their working methods to reflect the fact that their particular urban area was different to the surrounding practices, so that QOF scores were not comparing like with like.

We looked at audits carried out in relation to infection control and prescribing practise. Where the audits had identified that improvements were required the practice had taken action. For example prescribing audits had revealed weaknesses in the training of patients in inhaler technique (for respiratory disease). A practice representative had attended a training event on the issue, produced a short report and reviewed patients on certain inhalers. This showed that the practice were implementing best practise identified from clinical, and other, audits.

Patient experience and involvement

The practice had systems in place to seek and act upon feedback from patients. There was an active Patient Participation Group (PPG). We looked at the minutes of meetings of the PPG. We saw that the practice responded to patients views. For example the practice patient survey had identified that a number of patients were interested in assistance to carers. A representative of a local carer's charity had been contacted and had agreed to talk to the PPG about what was available. Other members of the PPG had collated information on what local services were available to carers and this was available to patients or carers attending the practice. The PPG had looked at missed appointments and had carried a survey. The forum discussed what action could be taken but also acknowledged that this was a complex issue as many non-attenders had other problems.

There was annual patient survey, this had shown a strong potential for use of text appointments and to a lesser degree texting of test results. In response a text appointments system had been implemented.

Staff engagement and involvement

Staff we spoke with felt that the practice was open to suggestions from staff. They were aware of the whistleblowing policy and though none had had occasion to call upon it staff felt that if they had something important to say they would be listened to. There was a range of meetings to gain staff views, these included nurses meetings, receptionists' meetings, practice business meetings and a whole practice meeting across all the departments. From the meeting minutes we saw that staff were made aware of how patients felt about the practice, good and bad. For example in the receptionists' meeting staff were reminded to treat all patients with respect following a particular complaint. At the end of meeting the staff were told of the many patients' comments praising the reception staff.

Learning and improvement

Staff were aware of the incident reporting policy and we looked at the review of significant events. The review showed who had made the report for instance a hospital or a particular staff member, a summary of the event and the action or learning point. Some events were clinical in nature and the learning was confined to clinicians. Others involved the practice as a whole where for example, staff felt that opportunities were not being offered fairly across

Are services well-led?

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

the practice. The learning points showed an open approach to the issues even when the outcomes might have been uncomfortable for the staff involved. What went well was discussed as well as any negative points. The learning generated action plans to reduce the risk of the event happening again.

Staff said that they were supported to develop their skills. We saw that the advanced nurse practitioner had developed their competency with the support of the practice. Administrative staff also talked of the training that they had had which included managing complaints and time management. There was an overall training plan where external courses and in house training was scheduled. There were six half day sessions of protected learning time where the practice closed for the afternoon. Some were internal training session and some with external speakers. This allowed staff to spend training time together when common issues such as changes to practice policies and procedures could be shared amongst all staff.

Identification and management of risk

The partners met quarterly and this included a strategic discussion on the future of the practice. Recent issues had included the effect of the retirement of a neighbouring GP, some discussion about a proposed housing development nearby and the general increase in demand associated with an aging population.

Risk assessments were used to consider individual risks to patients, staff and visitors to the practice. These included risks to the fabric of the building, risks of an interruption to services and the risks posed by severe weather. There were steps in place to mitigate the risks.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

We found that the service was responsive to the needs of older patients. Older patients were part of the general practice population. Older patients were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. Every patient over who was over 75 had an allocated GP. There were specialist clinics and information available to support patients who were over 75 with maintaining a healthy lifestyle. Clinics and advice included weight, blood pressure diet and specifics such as blood sugar for those who needed it.

The practice was caring of older patients for example there was a dementia service available. GPs would visit older patients at home if they were not able to go to the surgery. There were systems in place to cater for the current demands of older patients and to recognise the future demand.

Our findings

Safe

The practice provided annual flu vaccination clinics for older patients, to provide protection and prevention from contracting the virus and associated illness.

We found that the practice had systems in place to manage medicines safely and help protect older patients from the risks associated with medicines.

We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for older patients.

Effective

The GPs within the practice had personal patients lists and had therefore each patient over 75 years of age had a named doctor. There was a dementia nurse service this meant that a speciality particularly prevalent older patients was catered for.

There was a wide choice of health promotion material both on paper and web based. Much of the material related to ailments afflicting older patients.

Caring

The practice held three monthly palliative care meetings with other agencies. This meant that those patients, most of whom were older patients and whose needs were often complex received care that was coordinated across different disciplines.

Many of the patients that we spoke to were older patients. Without exception they felt that the GPs were caring and treated them with dignity and respect.

Responsive

Older patients said that GPs visited them at their homes if they were not able to get to the practice.

Well-led

We saw evidence that the practice undertook clinical audits to improve outcomes for older patients. The results were reviewed against national data to determine any changes that could be made to care/treatment pathways and

Older people

clinical therapies to improve outcomes for older patients. For example there had been an audit of calcium and vitamin D therapy, an audit impacting particularly on older patients where osteoporosis and decreased bone density are recognised clinical factors.

The partners reviewed strategic factors impacting on the practice. This included how demographic changes in particular the increasing number of older patients might impact on need to recruit more staff or staff with particular skills.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

We found that the service was effective in treating the needs of patients with chronic conditions. Patients with long term conditions were part of the general practice population. They were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. The practice offered annual flu vaccinations routinely to patients with long term conditions. There were treatment plans for some long term conditions the plans were monitored and kept under review by multi-disciplinary teams. There were clinics specifically for the treatment of long term conditions such as asthma and diabetes. The practice was responsive to any urgent care needs that patients with long term conditions required. It was well-led in relation to improving outcomes for patients with long-term conditions.

Our findings

Safe

The practice provided annual flu vaccination clinics for patients with long term conditions, to provide protection and prevention from contracting the virus and associated illness.

Effective

There was a wide choice of health promotion material both on paper and web based. There was a page of useful links which gave access to information on long term conditions such as asthma and diabetes, heart and kidney disease. Registers were kept to identify patients with long term conditions conditions. There were practice nurses with specialisms in chronic diseases such as asthma and cardiovascular disease. In addition there were specialist clinics such as anticoagulant monitoring, asthma, coronary heart disease and diabetes. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included hospice nurses who met the needs of patients with life limiting conditions.

There were examples of the use of national and local guidance including, care planning for patients with deep vein thrombosis (DVT) and protocols for the treatment of patients with lymphoedema (a long-term condition causing swelling of body tissue).

Caring

Patients with chronic conditions told us that their well-being was monitored and they were re-called for routine checks and follow-up appointments on a regular basis. They also told us that they were treated with dignity and care by their GPs. They particularly praised the nursing staff for their care and kindness.

Responsive

There were specialist nurses clinics for chronic disease such as asthma, coronary heart disease and diabetes. In addition there were specialist clinics such as anticoagulant

People with long term conditions

monitoring, asthma, coronary heart disease and diabetes. There was a GP with a special interest in Rheumatology, rheumatic diseases are often linked to chronic conditions such arthritis and fibromyalgia (a chronic disorder characterized by widespread pain and diffuse tenderness). The nurses used care plans for patients with Asthma. The practice had a named respiratory nurse who was involved in the care of patients with COPD. The practice also used telemonitoring to maintain support for some of these patients. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included hospice nurses who met the needs of patients with life limiting conditions.

Well-led

We saw evidence that the practice undertook clinical audits to improve outcomes for patients with long term conditions. For example to monitor treatments in chronic conditions and to take effective action the practice had undertaken an audit of pulmonary rehabilitation in the management of chronic obstructive pulmonary disease COPD. The practice had believed that referral for patients had fallen below the expected standard. The audit had resulted in a discussion with other partners and a decision to discuss this type of rehabilitation with the patients and to refer if appropriate. There were plans to re audit the same treatment in 12 months' time to measure any change.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice offered dedicated clinics to patients in this population group such as midwifery clinics and a health visitor service. Mothers, babies, children and young patients were part of the general practice population. They were cared for as part of the practice's patient centred approach which focused on individuals' needs and preferences. The practice was responsive and effective with one of the GP partners having a special interest in women's health. We saw that referrals to other community based services were made, in order to provide these patients with additional support. The practice was well led in regard to this group as there was a nominated lead for safeguarding children. We saw that safeguarding referrals had been effectively made.

Our findings

Safe

The practice provided annual flu vaccination clinics for mothers, babies, children and young patients, to provide protection and prevention from contracting the virus and associated illness.

We found that the practice had systems in place to manage medicines safely and help protect mothers, babies, children and young patients from the risks associated with medicines.

We found that the practice had appropriate infection control procedures and systems in place to minimise the risks of cross infection for mothers, babies, children and young patients.

There was a GP partner lead for safeguarding. All staff had had up to date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral.

Effective

There was a wide choice of health promotion material both on paper and web based. Sections of the material concerned family planning, child immunisation and breast cancer. There were child health appointments and midwifery clinics at the practice. One of the GP partners had a special interest in women's health. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included a health visitor to meet the needs of children under five.

Caring

We spoke with patients who were mothers. All said that they were very pleased with the care and service that they had received. One patient had a large family and felt the GPs were very accommodating. Another patient who was pregnant had recently come to the practice because of her concerns. She was referred for an emergency scan and felt the she had been dealt with speedily and very competently. The practice had implemented their own coding on the

Mothers, babies, children and young people

patient record so that they could identify vulnerable families. This allowed them to focus on them, to help them receive the assistance they might need. This was in line with recent National Institute for Health and Care Excellence (NICE) guidance.

Responsive

There were child health and midwifery clinics. The was a GP with a special interest in women's health. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included a health visitor to meet the needs of children under five.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice was responsive to needs of patients in this population group. The practice had extended practice hours to be available to the working age population. There were clinics such as well man clinics to support this population group. The was healthy living advice. There was an evening surgery on day a week and GP had telephone appointments.

Our findings

Effective

People of working age and recently retired were offered a health check if they joined the practice as new patients. There was a range of clinics and services such as a diabetes, blood pressure and general check-ups to service the needs of the working age patients. There was advice on healthy living. On the practice web site there was a page of information links which gave access to information such as asthma, diabetes, sexual and mental health and smoking cessation.

Responsive

The practice offered a commuter clinic every Tuesday evening to meet the needs of patients such as those who found it difficult to attend during the day because of their work. GPs also had telephone appointments for these who found it difficult to attend during standard working hours.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

We found that the service was caring about vulnerable patients. There was disabled access, which had been specifically installed to provide access for vulnerable patients. The practice responded to the needs of the homeless and regularly had homeless patients on the GP list. There were appointments available on the day so that vulnerable could be seen on the day they attended the practice.

Our findings

Safe

The practice provided annual flu vaccination clinics for patients in vulnerable circumstances, to provide protection and prevention from contracting the virus and associated illness.

There was a GP partner lead for safeguarding vulnerable patients. All staff had had up to date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral.

Effective

The practice provided routine care to patients in vulnerable circumstances who may have poor access to primary care. The practice served homeless and travelling patients as the need arose. The practice commonly dealt with homeless patients because of the large number of support agencies in the locality. There were translation services available though the practice had had little cause to use them.

Caring

The premises were approached by a ramp which provided easy access for patients with reduced mobility. We saw staff helping patients with reduced mobility. There was limited disabled parking available. There were duty GPs available. All of their appointments were available on the day. This helped to ensure that vulnerable patients could register with the practice and be seen on the day if necessary. On the day of the inspection we spoke with two patients who had registered with the practice on that day and who were seen on that day. The practice had implemented their own coding on the patient record so that they could identify vulnerable families. This allowed them to focus on them, to help them receive the assistance they might need. This was in line with recent National Institute for Health and Care Excellence (NICE) guidance.

People in vulnerable circumstances who may have poor access to primary care

Responsive

We saw evidence that GPs or the district nurse would support and treat patients at home if that was necessary as some vulnerable patients could find it difficult to attend the practice for care and treatment.

Well-led

<Findings here>

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate systems and methods of referral were in place in order to provide patients with mental health problems access to specialists, these included psychologists, counsellors and support workers. GPs in the practice had individual lists and this increased the likelihood of more continuity of care. Results of OQF assessment showed that the practice had focussed successfully on mental health issues.

Our findings

Safe

There was a GP partner lead for safeguarding. All staff had had up to date safeguarding training in both adult and child protection. There were policies in place to direct staff on when and how to make a safeguarding referral.

Effective

There was a wide choice of health promotion material both on paper and web based. A section of the material was about mental health and related to Mental Health and Counselling. There were a number of links to other organisations such as the Royal College of Psychiatry, Mind - the mental health charity and other mental health organisations.

Registers were kept to identify patients with specific mental health conditions. As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included psychologists, counsellors and support workers who met the needs of patients with mental health problems. There was a dementia nurse service. The practice consistently scored highly in the QOF results relating to the care of patients experiencing poor mental health. In particular the results taken over the last few years across the indicators had showed a sustained improvement in outcomes.

Caring

To assit in continuity of care the practice GPs had a specific list of patients so patients were usually seen by the same GP. There were double appointments available if necessary for those with mental health problems who needed more time to talk to their GP.

Responsive

As well as the GPs and nurses employed at the practice there were other team members attached to the practice. These included psychologists, counsellors and support workers who met the needs of patients with mental health problems.

People experiencing poor mental health

Well-led

The sustained improved performance in mental health outcomes as evidenced by the improved QOF scores, demonstrated a commitment to provide appropriate care to this group of patients by those leading the practice.