

Sutton Valence Surgery

Quality Report

South Lane
Sutton Valence
Maidstone
Kent

ME17 3BD

Tel: 01622842303

Website: www.suttonvalencesurgery.co.uk

Date of inspection visit: 23 August 2017

Date of publication: 30/11/2017

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

Outstanding



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Outstanding



Are services well-led?

Outstanding



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	12

Detailed findings from this inspection

Our inspection team	13
Background to Sutton Valence Surgery	13
Why we carried out this inspection	13
How we carried out this inspection	13
Detailed findings	15

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sutton Valence Surgery on 23 August 2017. Overall the practice is rated as outstanding.

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

- There was an open and transparent approach to safety and a system for reporting and recording significant events. The practice shared learning from safety incidents with other nearby practices on a regular basis.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. The results from the survey were significantly higher than national and local averages.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought and acted upon feedback from staff and patients.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

There were areas of outstanding practice.

- The practice supported elderly patients living independently to engage in regular physical activity. The practice provided provision such as a walking for health group and a beginner cycling for health group. The practice recognised that this also helped to reduce social isolation in this population group.

Summary of findings

- There was a weekly medicines delivery round to housebound, usually elderly patients. This was carried out by a member of the PPG, or in their absence by the principal GP.
- The practice had a substantial number of patients from Romani Gypsy and travelling communities. They adjusted the appointments system to make it easier for patients from those communities to access healthcare.

- The practice had pronunciation guidance for staff for commonly cited Polish and Bulgarian names.

There was one area where provider should make improvements:

- Review procedures for the recording of minor surgery operations to ensure that all relevant details are included.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- The practice had staff member who acted as the Freedom to Speak up Guardian and the staff we spoke with knew their identity and function.
- There was a record of “near miss” events at the dispensary. These were analysed and reported on annually.
- The GPs met with other local GPs monthly they discussed recent safety alerts, best practice and near misses and safety events across all the practices so that opportunities to learn from external safety events were identified.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above the national averages.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge 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.
- End of life care was coordinated with other services involved.

Summary of findings

- The record of minor surgery did not include all the necessary details

Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice significantly higher than others for all aspects of care. The survey information showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There was a system to help ensure that all carers were contacted, at least annually, to check whether their needs had changed and how, if possible, the practice could support them.
- The practice encouraged and supported a local voluntary car service, which provided transport for patients in the rural community to help them access health services.
- One of the members of the patient participation group had a weekly medicines delivery round. This entailed taking medicines to housebound, rurally isolated, usually elderly patients. When the services was not available, for example because of annual leave, the principal GP undertook the round.

Good



Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Data from the national GP patient survey showed the practice results scored extremely highly for continuity of care and access to services.
- The practice had high number of patients from the traveller community. Arrangements for appointments for them were adjusted to reflect both the literacy difficulties and cultural preference of that community.

Outstanding



Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from two examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as outstanding for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a planned approach to succession planning which involved all the staff.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. The practice proactively reviewed governance and performance management arrangements. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. The system for recording complaints and significant events required the practice to consider the issue of duty of candour and to record a decision.
- There was a culture of openness and honesty. The practice had a staff member who acted as the Freedom to Speak up Guardian and the staff we spoke with knew their identity and function. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group. For example staff and the PPG had cooperated to produce a patients' charter for the practice.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

Outstanding



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of older patients.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example through the support provided by the Healthy Walking and Healthy Bicycling groups.
- All patients over the age of 85 years old were offered a face-to-face review annually.
- There was a weekly medicines delivery round to housebound, usually elderly patients. This was carried out by a member of the PPG, or in their absence by the principal GP.
- The practice provided a weekly ward round at the local nursing home to manage on-going problems.
- Older patients were contacted by telephone or visited following hospital discharge.

Outstanding



People with long term conditions

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of patients with long-term conditions

Outstanding



Summary of findings

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the clinical commissioning group (CCG) and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 75% compared with the national and local average of 77%.
- There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- The practice achieved 100% of QOF points for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, depression, dementia, heart failure and hypertension. In all these cases the practice results were higher than the clinical commissioning group (CCG) and national averages. Exception reporting, at seven per cent, was lower than the national and local averages
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of Accident and Emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.

Outstanding



Summary of findings

- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. There was a weekly midwife clinic. The practice followed up on missed child immunisations by telephone.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours.
- 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.
- GPs took blood samples from patients' in early morning commuter clinics if they had difficulty attending phlebotomy appointments because of their working hours.

Outstanding



People whose circumstances may make them vulnerable

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of patients whose circumstances may make them vulnerable

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- 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.

Outstanding



Summary of findings

- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- The needs of vulnerable patients were discussed at the weekly practice meeting to ensure their needs were met.
- The practice had a substantial number of patients from Romani Gypsy and travelling communities. They adjusted the appointments system to make it easier for patients from those communities to access healthcare.

People experiencing poor mental health (including people with dementia)

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of patients experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.
- Twenty three out of 25 patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months (92%), which is higher than the national average (84%).
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Performance for mental health related indicators was similar to the clinical commissioning group (CCG) and national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have an agreed care plan during the preceding 12 months was 100% compared with the CCG average of 92% and the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.

Outstanding



Summary of findings

- The practice had information available for patients experiencing poor mental health about how they could 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 interviewed had a good understanding of how to support patients with mental health needs and dementia. The practice was a member of the Dementia Action Alliance a group which connects organisations and individuals, shares best practice and takes action on dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing significantly better than the local and national averages. Two hundred and seven survey forms were distributed and 114 were returned. This represented 3% of the practice's patient list.

- 97% described their overall experience of the practice as good compared to the CCG average of 88% and the national average of 85%.
- 97% described their experience of making an appointment as good compared with the CCG average of 78% and the national average of 73%.
- 93% said they would recommend the practice to someone new to the area compared to the CCG average of 82% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards all of which were positive about the standard of care received. There was praise for the clinical staff, particularly for their listening skills and for the reception and administration staff for being helpful in providing the appointments that patients wanted.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Sutton Valence Surgery

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 two members of the CQC medicines team.

Background to Sutton Valence Surgery

The Sutton Valence Surgery is a GP practice located in the village of Sutton Valence, Kent. It provides care for approximately 3500 patients. The practice is in a rural area.

There is a single, male, GP who is the principal of the practice. He is assisted by a female salaried GP. There are three practice nurses, all female, one nurse is an advanced nurse practitioner and a prescriber. There is a female healthcare assistant. There is a practice manager and a deputy practice manager, administration, reception and secretarial staff.

The age of the population the practice serves differs from the national averages. There are fewer people aged less than 40 years old and more people aged 45 to 75 years old. The numbers of patients over 75 years of age is the same as the national average. The practice reported that they cared for a considerable number of migrant, mostly agricultural, workers from Eastern Europe.

The practice has a general medical services contract with NHS England for delivering primary care services to local communities. The practice offers a full range of primary medical services and is able to dispense medicines to

those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy premises. Approximately 90% of patients are eligible to use this service. The practice is not a training practice.

The practice is open between 8am and 6.30pm Monday to Friday. There is an evening surgery until 7.30pm on Wednesdays and a morning surgery from 7.10am on Fridays. The surgery is a purpose built building. All the consulting and treatment rooms are on the ground floor.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by Integrated Care 24 through the NHS 111 service. There is information, on the practice building and website, for patients on how to access the out of hours service when the practice is closed.

Regulated activities are carried out from:

South Lane
Sutton Valence
Maidstone
Kent
ME17 3BD.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 23 August 2017. During our visit we:

- Spoke with a range of staff, including the GP, nurses, receptionists and administrative staff. We spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
- We spoke with the care coordinator from the local council.

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 living 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.

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 managers 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).
- There had been 11 significant events reported in the last 12 months. We saw that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we saw an incident, involving two patients with similar names, where the treatment notes had been recorded on the wrong patient record. The error was identified and flags placed on both patients' records to help prevent a similar incident in the future.
- The practice also monitored trends in significant events and evaluated any action taken.
- The practice GPs met with other local GPs monthly (called the journal club) they discussed recent published research, safety alerts and best practice. We saw that they discussed a recent "near miss". The patient presented with vague symptoms including tiredness and feeling stressed which might easily have been dismissed as transitory. The patient had a serious condition. The club discussed the associated symptoms, the relevant professional guidance and the importance of early blood tests in such cases.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.

- Arrangements for safeguarding 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...
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding. All staff had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and the advanced nurse practitioner were trained to child protection or child safeguarding level three. The remaining practice nurses were trained to level two.
- We reviewed one case of a safeguarding referral. We saw that it was dealt with in accordance with the local protocols.
- A notice in the waiting room advised patients that chaperones were available if required. There were also notices in the treatment and consultation rooms. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice had a staff member who acted as the Freedom to Speak up Guardian and the staff we spoke with knew their identity and function. A Freedom to Speak up Guardian is able to act as an independent and impartial source of advice to staff. This role is identified as best practice by NHS England.

The practice maintained appropriate standards of cleanliness and hygiene.

- The premises were clean and tidy. There were cleaning schedules and systems for monitoring their effectiveness. There was a monthly audit of cleaning with each area given a score to identify if there was any deterioration in standards.
- One of the practice nurses was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. 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. One of the nurses had qualified as an independent prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The healthcare assistant was trained to administer vaccines.
- The principal GP was responsible for the dispensary. All members of staff involved in dispensing medicines had received appropriate training and their competence was checked regularly. Dispensary staff showed us standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of regular review of these procedures in response to incidents or changes to guidance in addition to annual review. The practice was accredited by the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.

We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence

of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. Five staff were trained fire wardens
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

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.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- 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.

Are services safe?

- 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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of 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 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the clinical commissioning group (CCG) and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was acceptable was 75% compared with the national and clinical commissioning group (CCG) average of 77%.
- The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification, within the last twelve months was 92% which was 11% above the CCG and national average.
- Performance for mental health related indicators was higher than the CCG and national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed care plan during the preceding 12 months was 100% compared with the CCG average of 92% and the national average of 89%.

- The practice achieved 100% of QOF points for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, depression, dementia, heart failure and hypertension. In all these cases the practice results were higher than the CCG and national averages.
- Exception rates for clinical domains were similar to or lower than national averages (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).

There was evidence of quality improvement including clinical audit:

- There had been four clinical audits commenced in the last two years, three of these were completed audits where improvements had been made and monitored.
- Findings were used by the practice to improve services. For example the practice conducted a two cycle audit of the treatment of patients with hypertension, to check that the treatment accorded with NICE guidance. The first cycle identified that 89% were treated correctly. The results were discussed amongst the practice staff and the audit repeated six months later and identified 98% of patients were treated in accordance with the guidelines.
- The practice GPs met with other local GPs monthly (called the journal club). They discussed recent NICE guidance, published research and cases with learning points. We saw that two of the subjects discussed, the consumption of processed meat and the impact of the age of the treating physician on the patient's outcome were directly concerned with improving outcomes for patients. The GPs used the findings, about processed meat consumption, to encourage patients, by setting out the evidence, to adopt healthier lifestyles. The discussion about the age of the treating physician, demonstrated self-awareness on the part of the GPs.
- The practice carried out minor surgery. Record keeping for this lacked in two areas. Firstly the batch numbers of local anaesthetics were not recorded in the register of operations. Secondly, the register recorded when patients' samples were sent for pathology examination but there was no corresponding entry to ensure that the

Are services effective?

(for example, treatment is effective)

result of the examination had been received by the practice. The practice provided, to the inspection team, a new register for minor operations that addressed those two failings.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge 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, 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 there had been training in diabetes management and one nurse was due to attend spirometry training (a spirometer is a device for assessing breathing).
- 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. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. One staff member had identified a need for some management training and had recently been supported to attend a three day management course.
- Staff received training that included: safeguarding, 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.

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.
- From documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice conducted a weekly ward round at the local nursing home to manage ongoing problems. Older patients were also contacted by telephone or visited following hospital discharge.

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 ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. 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.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

There was a weekly practice meeting and we saw from the minutes that vulnerable and end of life care patients were standing items on the agenda.

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.

Are services effective?

(for example, treatment is effective)

- 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. For example through an audit of consent to minor operations.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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.
- The practice supported elderly patients living independently to engage in regular physical activity. The practice provided provision such as a walking for health group and a beginner cycling for health group. The practice recognised that this also helped to reduce social isolation in this population group.

Standard childhood immunisations for the practice were over 90% for all two and five year olds. When children missed an immunisation the practice telephoned the family to follow up on the non- attendance.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the national average of 81%. The practice telephoned patients who did not attend for their cervical screening test to remind them of its importance. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages, for example in Polish and Bulgarian, as there were patients from those areas of Eastern Europe, registered with the practice, working in the vicinity. They ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. 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.

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.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 32 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was consistently higher for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 97% say the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 88% and the national average of 86%.
- 98% 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%.
- 93% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.

- 97% of patients said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 95% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 99% 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%.
- 98% found the receptionists at the practice helpful compared with 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 comment cards we received was also positive and aligned with these views. We saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were consistently higher than local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 86%.
- 90% say the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 95% say the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

Are services caring?

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

- Staff told us that interpretation 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.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

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. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 29 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. This staff member worked in partnership with a care coordinator from the local social services and was able to help with timely support such as, temporary care to enable patients to return to their homes quickly following an admission to hospital. We spoke with the local care co-ordinator (a person who supervises

interdisciplinary care by bringing together the different specialists whose help the patient may need). They confirmed that the practice regularly referred appropriate patients. The referrals were accompanied by informative documentation that helped to get the patients the assistance they needed in a timely way.

The carers champion had regular contact with carers. The champion had a system to help ensure that all carers were contacted, at least annually, to check whether their needs had changed and how, if possible, the practice could support them.

There was a "carer's corner" in part of the waiting room. This provided details of support services, such as access to respite care, and local services such as the local voluntary car service. This service, which the practice encouraged and supported provided transport for patients in the rural community to help them access services including the practice. Some patients who might otherwise have had to be seen at home were able to come to the practice. This, the practice believed, contributed to the low home visiting rate which, given the time needed to reach the rural areas of the practice, made more GP time available for appointments.

The practice were members of Carers Association UK. This gave the practice access to information such as fact sheets, for example on claiming support benefits, that the practice used to benefit carers.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. There was a bereavement register and patient's notes were marked so that staff were aware when a patient had suffered bereavement.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Wednesday until 7.30pm and Friday from 7.10am for working patients who could not attend during normal opening hours. Patients who needed blood tests as a result of these consultations, had blood taken at the time, by the GP, rather than having to make a further appointment.
- 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.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- 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 or were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop. The hearing loop was portable which facilitated communication not only at the reception desk but during consultations with clinical staff.
- The practice used a web based system to confer directly with secondary care specialists. This allowed more patients to be quickly and successfully treated by their GPs.
- The practice had implemented the NHS England Accessible Information Standard to help ensure that disabled patients received information in formats that they could understand and received appropriate support to help them to communicate.
- The practice had a substantial number of patients from Romani Gypsy and travelling communities. They understood the issues facing this group, for example from both literacy difficulty and cultural preference, in making pre-booked appointments. The practice made itself readily available to patients from that community

who were not held to the appointment times. They were often seen when they arrived at the surgery or with flexible arrangements to help ensure their needs were met.

- There were flexible appointment times as well as longer appointments for those who relied on friends and family to attend. These were flagged on the appointment record so reception knew which patients might be experiencing such difficulties.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 12.30pm and from 3.30pm to 5.30pm daily. Extended hours appointments were offered on Wednesday until 7.30pm and Friday from 7.10am. Appointments could be booked up to 12 weeks in advance and urgent appointments were available on the day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was considerably higher than local and national averages.

- 93% were satisfied with the surgery's opening hours compared to the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 96% found it easy to get through to the practice by telephone compared with the CCG average of 74% and the national average of 71%.
- 98% were able to get an appointment to see or speak with someone the last time they tried compared with the CCG average of 88% and the national average of 84%.
- 98% said the last appointment they got was convenient compared with the CCG average of 85% and the national average of 81%.
- 97% described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 82% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.

The practice undertook an audit of patients' satisfaction with appointments. This had shown that 97% were satisfied with the appointments system and that 60% of patients who asked for an appointment on the day that they called the practice received one.



Are services responsive to people's needs?

(for example, to feedback?)

We saw on the day of the inspection that there were urgent appointments available.

The practice had a system to assess:

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

In such cases the patient call was passed to a duty doctor who talk with the patient to discuss the presentation and decide on the course of action. 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.

One of the members of the patient participation group had a weekly medicines delivery round. This entailed taking medicines to housebound, usually elderly patients. We spoke with this person. They told us that in carrying out the deliveries they sometimes noticed if a patients' condition had deteriorated and brought this to the attention of staff and it was always actioned. The person told us that patients appreciated this service not simply because it helped them to get their medicines but also because it helped to reduce a sense of isolation. When the service was not available, for example because of annual leave, one of the GPs undertook the round.

Staff always took patients' personal, cultural, social or religious needs into account. For example if particular patients liked to be called by a given name this was noted on the patient's record. The practice had pronunciation

guidance for staff for how to pronounce commonly cited Polish and Bulgarian names. These nationalities being most common amongst the agricultural eastern European workers.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, there were posters in reception and details were included on the practice's leaflets and the practice's website

We looked at two complaints received in the last 12 months and found these were satisfactorily handled. The patients received timely, comprehensive and honest answers to their correspondence. Lessons were learned from individual concerns and complaints and also from analysis of trends. Action was taken to as a result to improve the quality of care. For example, one complaint concerned a patient seeing a GP, receiving advice, but having to contact the NHS 111 service later as the condition deteriorated. The learning from the event was that the advice given to the patient, about how to recognise if the condition deteriorated, could have been better. The learning was shared with the clinical team.

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. This was also set out in the practices' charter.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- There was a planned approach to succession planning. The practice recognised that major housing developments in the area (an increase in the population of about 8000), and the strategy set out in the NHS forward view called for a review of GP services. As a result a merger was planned between this GP practice and an adjacent practice. The practice approached this systematically. There was a whole day meeting between the principals, away from practices. The agenda included an assessment of strengths and weakness, consideration of what type of practice the leaders wanted to develop and an action plan to monitor progress. There were meetings with staff from both practices to develop the vision and values for the new practice. There were meetings between the two practice participation groups (PPG). The practices had organised a public meeting several hundred patients attended. The practice took several proposals from the meeting including having a single point of contact for public concerns. Other external agencies such as the clinical commissioning group (CCG), NHS England and parish and local councils had been involved throughout the process. The merger was planned for April 2018.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example there were leads for caring, finance and safeguarding

- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- The practice proactively reviewed governance and performance management arrangements. For example they worked with the adjoining practice to identify best practice from both organisations to develop common governance systems, that would be in place by the time of the merger.
- The practice was accredited by the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained.

A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. This was based around a wide range of data sources including: There was regular review of the practice performance against a wide range of data:

- NHS England data (GP outcomes).
- Quality and Outcomes Framework.
- Local clinical commissioning group (CCG) data.
- Eclipse data (this is a real time one-line tool for benchmarking in long term conditions).
- Medicines optimisation scheme (a scheme to promote evidence based cost effective prescribing).
- Referrals data, including Kinesis (a web-based software system that directly links GPs to hospital specialists for rapid access to expert advice).
- Audits.
- Significant events and/or complaints.

The data was used to drive improvement. For example the practice identified that orthopaedic referrals to secondary care were higher than was expected, compared with similar practices. All such referrals were therefore reviewed by a lead clinician before forwarding.

We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the principal demonstrated they had the experience, capacity and capability to run the

Are services well-led?

Outstanding



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

practice and ensure high quality care.. They told us they prioritised safe, high quality and compassionate care. Staff told us the management were approachable and always took the time to listen to all members of staff.

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). This included support training for all staff on communicating with patients about notifiable safety incidents. There was a culture of openness and honesty. We looked at some examples in detail and found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- 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 at team meetings and felt confident and supported in doing so. The practice had a staff member who acted as the Freedom to Speak up Guardian and the staff we spoke with knew their identity and function. A Freedom to Speak up Guardian is able to act as an independent and impartial source of advice to staff. This role is identified as best practice, for primary care providers, by NHS England.
- We noted there were regular team away days. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported.
- All staff were involved in discussions about how to run and develop the practice, and the management 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 and valued feedback from patients and staff. It proactively sought feedback from:

- Staff. There were high levels of staff satisfaction. Staff we spoke with were proud of the organisation as a place to work and speak highly of the culture. There are consistently high levels of constructive staff engagement. For example we saw a poster advertising a forthcoming practice meeting and encouraging all to submit suggestions for the agenda.
- Patients through the patient participation group (PPG) and through surveys. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had developed a list of contacts for local organisations that patients, particularly those who might be isolated, might wish to engage with. These included the local choral, gardening, walking and cycling groups.
- The NHS Friends and Family test, complaints and compliments received
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. For example staff and the PPG had cooperated to produce a patients' charter for the practice. The charter was available in the waiting area and was handed to new patients together with the practice leaflet. The charter set out what the practice endeavoured to achieve. For example repeat prescriptions were signed by the patients' usual GP whenever possible to help with continuity of care. The charter also set out the patients' responsibilities such as being courteous, to staff and other patients, at all times

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.

- The practice was the driving force behind a bicycle training initiative. Together with Kent County Council and an accredited bicycle training organisation they had run two pilot sessions of adult cycle training. The pilot

Are services well-led?

Outstanding



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

sessions, held at the practice, were well attended and the practice, together with adjoining practices intended to commission a scheme where GPs could refer patients to adult bicycle training sessions.

- The practice held a monthly meeting with neighbouring GPs to discuss recent published research, (the group was called the journal club), learn from safety events and share best practice, concerns and local trends.
- The practice had had educational events where consultants provided insights into recognising or dealing with aspects of their different specialities.