

# Borough Green Medical Practice

## Quality Report

Quarry Hill Road  
Sevenoaks  
Kent  
TN15 8RQ  
Tel: 01732 883161  
Website: [www.boroughgreenmedicalpractice.co.uk](http://www.boroughgreenmedicalpractice.co.uk)

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

## Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Borough Green Medical Practice on 17 August 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients 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.
- The practice had developed a wide range of other services for patients. The practice objective was to place the patients at the heart of the services, rather than the patients being sent through the health care system to access the services.
- The practice recognised that the effective governance of the dispensary was particularly important, as they dispensed medicines to approximately 5,600 patients. They had appointed a dispensary manager, two senior dispensers, four dispensers and a dispensary receptionist, in order to ensure the dispensary was managed and governed to a high standard.

# Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvements are:

- Ensure that action is taken to address the areas of concern identified in the infection control audit.
- Ensure that systems to routinely check the equipment used in emergencies are safe. In order to ensure equipment is within its expiry date, sterile and fit for purpose.

The areas where the provider should make improvement are:

- Continue to ensure that the recording of medicines used during minor surgery are appropriately recorded.
- Continue to ensure there is a system to check and respond to all routine correspondence sent to the practice by other service providers.

**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 requires improvement for providing safe services.

- 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 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.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. In that, appropriate action had not been undertaken to address the areas of concern identified in the infection control audit undertaken in July 2015 and routine checks of equipment used in emergencies had not identified that oxygen masks were out of date.
- All other risks to patients were assessed and well managed.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



### 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 higher than others for several aspects of care.

Good



# Summary of findings

- 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 easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice were in the process of conducting a Diagnostic Uncertainty Clinic pilot, in order to assess skin lesions. The purpose of the pilot was to support the CCG and reduce the two week cancer wait. The aim of this pilot was to support the practices' philosophy of working closely with secondary care providers, as well as reducing referral rates in specialist areas of care and treatment.
- Patients 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.
- The practice has close links with a local secondary school and provided presentations to year eleven students (children aged 15 or 16 years old) on coping with anxiety both before and during their exams.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



## Are services well-led?

The practice is rated as good 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 clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

Good



# Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The practice recognised that the effective governance of the dispensary was particularly important, as they dispensed medicines to approximately 5,600 patients. They had appointed a dispensary manager, two senior dispensers, four dispensers and a dispensary receptionist, in order to ensure the dispensary was managed and governed to a high standard.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels within the practice, clinical and non-clinical.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. It had a scheme for patients, who lived in one of the two residential care homes. This involved registering all the patients (with their consent) with one of two lead GPs who looked after that home. As required visits to nursing homes were conducted.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators were comparable to the local and national average. For example, 80% of patients with diabetes, on the register, in whom the last IFCCHbA1c is 64 mmol/mol (a blood test to check blood sugar levels) or less in the preceding 12 months compared to the local average 79% and the national average 78%).
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and 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.

Good



### Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Good



# Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 82%, which was comparable to the national average.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice has close links with a local secondary school and provided presentations to year eleven students (children aged 15 or 16 years old) on coping with anxiety both before and during their exams.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice held two midwife sessions per week, in order to ensure pregnant patients had access to pre and post-natal care.

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

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Good



# Summary of findings

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

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The percentage of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months was 71%, which was comparable to the national average.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 91%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice worked closely with the Admiral Nurses (specialist dementia trained nurses) in order to offer support to patients with dementia, as well as their carers.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

**Good**



# Summary of findings

## What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing significantly better than the local and national averages. Two hundred and thirty eight survey forms were distributed and 125 were returned. This represented 1% of the practice's patient list.

- 86% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 80% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.

- 92% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received one comment card which was positive about the standard of care received.

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

## Areas for improvement

### Action the service **MUST** take to improve

- Ensure that action is taken to address the areas of concern identified in the infection control audit.
- Ensure that systems to routinely check the equipment used in emergencies are safe. In order to ensure equipment is within its expiry date, sterile and fit for purpose.

### Action the service **SHOULD** take to improve

- Continue to ensure that the recording of medicines used during minor surgery are appropriately recorded.
- Continue to ensure there is a system to check and respond to all routine correspondence sent to the practice by other service providers.

# Borough Green Medical Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

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

## Background to Borough Green Medical Practice

Borough Green Medical Practice is a GP practice based in rural Borough Green, Kent with a catchment area of approximately 13,500 patients.

The practice is similar across the board to the national averages for each population group. For example, 18% of patients are aged 0 -14 years of age compared to the CCG national average of 17%. Scores were similar for patients aged under 18 years of age and those aged 65, 75 and 85 years and over. The practice is in one of the least deprived areas of Kent and has a majority white British population.

The practice holds a General Medical Service contract and consists of seven partner GPs (male). The GPs are supported by a salaried GP (female), a practice manager, an assistant practice manager, three practice nurses (female), three healthcare assistants (female), seven dispensers and an administrative team. A wide range of services and clinics are offered by the practice including asthma and diabetes.

Borough Green Medical Practice is arranged over two storeys, with all the patient accessible areas being located on the ground floor. The practices are accessible to patients with mobility issues, as well as parents with children and babies.

Borough Green Medical Practice is open 7.30am to 1.00pm and 2.00pm to 7.30pm on Monday and Tuesday, 8.00am to 1.00pm and 2.00pm to 6.30pm on Wednesday, Thursday and Friday.

The practice is able to provide dispensary services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy premises. This service is delivered by a dispensary team of a dispensary manager, two senior dispensers, four dispensers and a dispensary receptionist.

The practice is a training practice which takes foundation year two GPs (ST2 GP Registrars) and has one ST2 GP Registrar working at the practice, as well as two GP Registrars. Two of the GP partners are GP trainers and one partner provides training for Foundation Year doctors.

There are arrangements with other providers (Integrated Care 24) to deliver services to patients outside of the practice's working hours.

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) on 20 May 2014 and the practice was found to be compliant with all regulations inspected.

Services are provided from:

Borough Green Medical Practice, Quarry Hill Road,  
Sevenoaks, Kent, TN15 8RQ

# Detailed findings

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 October 2015.

During our visit we:

- Spoke with a range of staff (two GP partners, the practice manager, two practice nurses, a healthcare assistant, a salaried GP, three administrative staff, the dispensary manager and two dispensers) and spoke with seven patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed a comment card, as well as four letters, where a patient, member of the public or other healthcare providers shared their views and experiences of the service.

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

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

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

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

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

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. Records showed that actions had been taken to improve processes and that learning points had been implemented. However, they also showed that the practice were not reviewing at a later stage to check that the improved systems were working effectively.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident where a patient had been bitten by a dog, the practice investigated and found that NHS England had a website with information that contained relevant information for the treatment of bites, as well as details of how and where to obtain any relevant vaccine that may be required to treat the resulting wound. Records of the investigation and subsequent practice meeting minutes showed that this information had been shared with the clinical team.

### Overview of safety systems and processes

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

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three and nurses to level two or three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS 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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A GP partner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol and staff had received up to date training.

The practice had an annual infection control audit undertaken in July 2015 and we saw evidence that some action had been taken to address any improvements identified as a result. The audit highlighted that action needed to be taken to address issues with hand wash basins without overflows and appropriate taps, as well as carpets and material curtains used in clinical areas of the practice. A tour of the premise highlighted that whilst one consultation room had been updated and the issues addressed, the programme to address the remaining rooms identified had ceased. The practice were aware of this and had plans to continue with their programme for replacing items identified in the audit as unsafe.

We found that there was a system for the annual deep cleaning of carpets. However, this did not meet recommended best practice guidance of deep cleaning

## Are services safe?

at six monthly intervals. The system for the laundering of material curtains, located in clinical areas of the practice, did not meet the criteria as specified in The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. We raised this with the practice manager, who subsequently sent us documentary evidence following our visit to show; that the material curtains had been removed and replaced with disposable curtains, that carpets in clinical areas had been deep cleaned and new quotes had been obtained for the replacement of carpets and hand wash basins. Additionally, the infection control and prevention policy had also been updated to reflect the new processes.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

We spoke with GPs, dispensing staff and members of the non-clinical team, who told us there was a system for checking that repeat prescriptions were issued according to medicine review dates and also included the review of high risk medicines. Patients told us that they had not experienced any difficulty in getting their repeat prescriptions. Blank prescription forms and pads were securely stored. The system to monitor their use required improving as there was no audit trail of prescription batch numbers being allocated to GPs. We raised this with the practice manager, who subsequently sent us documentary evidence to show that the system had been improved following our visit.

The practice carried out regular medicine audits, with the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw evidence that the nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

The practice were engaged in the Medicines Optimisation Scheme for the CCG (Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time) and recently scored 19 out of an available 20 points when they were reviewed. One of the GP partners was the

lead, as well a member of the Medicines Optimisation Group. This role promoted the constant review and change of medicines prescribed by the GPs. This was supported by a commendation for the practice being well below the national average for the total and high risk antibiotic targets.

The practice offered a minor surgery service. The arrangements for managing medicines in relation to minor surgery generally kept patients safe. We looked at a sample of patients records and found that no entries had been made with regards to how much local anaesthetic had been given, the type of anaesthetic administered and the batch number from which the anaesthetic came. We raised this with the practice manager, who subsequently sent us documentary evidence to show that the systems for recording local anaesthetic administered to patients had been updated following our visit. This included ensuring the dosage, type and batch number being recorded into patient's notes, as well as the practices policies and procedures being updated to reflect the new process. Minutes of meetings showed the changes had been shared with all clinical staff.

Borough Green Medical Practice had an on-site dispensary and was able to provide dispensary services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy premises (dispensing to approximately 5600 patients). We looked at the arrangements for the dispensing of medicines to patients. There were named GPs responsible for the dispensary. The dispensary was located in a designated area on the ground floor. Systems to ensure that medicines were stored safely were effective. We checked the system for the receipt, storage and dispensing of medicines requiring refrigeration. The storage facilities for such medicines were suitable. Routine daily checks to ensure the correct temperature of the fridges used for storage were maintained. Staff told us of the procedure they would follow in the event that fridge temperatures were outside of the required range and these were in line with current guidance. Stock records and audit checks kept of the medicines held in the dispensary were clear. Staff told us that routine expiry date checks were undertaken; a spot check of shelf, refrigerator and controlled drugs stock found all medicines to be within expiry dates.

## Are services safe?

We spoke with dispensing staff, who had received appropriate training in pharmacy services. Dispensing staff told us that they were given opportunities for their continued learning and development. We looked at the practice's standard operating procedures for dispensing and found they reflected practice.

Adverse incidents and near misses relating to medicines were minimal. Historic incident records were reviewed and showed they had been appropriately recorded and actions had been taken to address them.

There was a system for the dispensing staff and GP to check all dispensed medicines and labels countersigned before being issued to patients. This helped to ensure they were dispensed accurately.

We reviewed the storage of dispensed medicines, ready for collection by patients. There was a process for routinely checking the medicines stored to ensure they had been collected by the patient.

The dispensary had appropriate arrangements for the secure storage of controlled drugs, including the control of keys. The process for the destruction of controlled drugs was completed in line with current guidance and legislation. We saw from the controlled drug register that medicines of this nature were recorded in the register as having been dispensed and issued to the patient. We found that routine checking of controlled drugs stocks was being carried out and recorded consistently.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety

representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

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

### Arrangements to deal with emergencies and major incidents

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

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

The practice had a defibrillator available on the premises and oxygen. We found oxygen masks to be used during a medical emergency to be out of date since October 2014. We raised this with the practice manager, who subsequently sent us documentary evidence to show that oxygen masks had been replaced following our visit.

- 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.
- 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

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

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

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available with 12% exception reporting (compared to the CCG average of 9%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- Performance for diabetes related indicators were comparable to the local and national average. For example, 80% of patients with diabetes, on the register, in whom the last IFCCbA1c is 64 mmol/mol (a blood test to check blood sugar levels) or less in the preceding 12 months (local average 79% and national average 78%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 91%.

There was evidence of quality improvement including clinical audit.

- There had been three clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, following an audit of patients prescribed a medication for diabetes, which impacts on their kidney function, the practice had reviewed patients, conducted appropriate blood tests and where necessary had reduced the dose of the medicine prescribed.

Information about patients' outcomes was used to make improvements such as: routinely reviewing patients on a certain medicine which had adverse cardiac (heart) side effects.

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety awareness, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. chronic obstructive pulmonary disease (COPD) and international normalised ratio (INR) management (a measure of how much longer it takes the blood to clot when oral anticoagulation (medicines that help prevent blood clots) were used).
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. For example, by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the

# Are services effective?

## (for example, treatment is effective)

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.

- 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.
- The practice was a training practice which takes foundation year two registrar GPs (ST2 GP Registrars) and had two ST2 GP Registrars working at the practice. Two of the GP partners are GP trainers and one partner provides training for Foundation Year doctors. The practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. We spoke with a member of the Deanery who supervised the registrar GPs who gave positive feedback about the way in which Registrars were trained by staff at the practice. Registrars we spoke with told us they enjoyed working at the practice, they felt included in the team and the training they received was exceptional. Testament to this was the fact that two of the GP partners were former Registrars at the practice.

### Coordinating patient care and information sharing

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

This included care and risk assessments, care plans, medical records and investigation and test results.

- The practice shared relevant information with other services in a timely way. For example, when referring patients to other services.

Documentation being sent to the practice, from other services, was not always being processed effectively. We looked at the way in which correspondence of this nature was processed and found that all urgent letters had been processed. However, routine letters were not dealt with for absent GP partners and there was potential for treatment changes and test requests to be delayed. This meant there was a potential risk of oversight, as they were not checked to make sure they were suitable to wait for the GP partner to return from their absence. We found that one GP had

been away from the practice for two weeks and had a significant number of more than 100 routine letters to process on their return. We raised this with the practice manager, who subsequently informed us that the issue had been discussed at a partners meeting and an audit/risk assessment would be carried out.

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. 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. Such meetings were attended by social services, hospice staff, mental health specialists, health and social care coordinators and long term conditions nurses.

Physiotherapists held three sessions a week at the practice and patients were referred by clinicians directly to the in house service. Additionally, two midwife sessions were available each week, in order to ensure pregnant patients had access to pre and post-natal care. Access to a health and social care coordinator was also available on a weekly basis.

### Consent to care and treatment

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

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

### Supporting patients to live healthier lives

# Are services effective?

(for example, treatment is effective)

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

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

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 84% and the national average of 82%. There was a policy to offer telephone and written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability. There were systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice achieved comparable results in relation to its patients attending national screening programmes for bowel and breast cancer screening. For example, 63% of eligible patients had been screened for bowel cancer, which was in line with the CCG average of 62% and the national average of 58%. Sixty eight percent of eligible patients had been screened for breast cancer, which was comparable to the CCG average of 74% and the national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 67% to 93% and five year olds from 81% to 94%.

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

There was a strong, person-centred culture at the practice. Staff were highly motivated to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by leaders.

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

The patient Care Quality Commission comment card 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 members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The comment card highlighted that staff responded compassionately when they needed help and provided support when required. Additionally, we received four letters from other healthcare providers who shared their positive views and experiences of the service.

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

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 87%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.

- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 86%.

### 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 card we received was also positive and aligned with these views.

We reviewed a sample of patients care plans and found these were extensive in content and where appropriate, included do not resuscitate orders as well as advanced directives. Where patients had attended appointments and there had been significant changes to their care, we saw that care plans were updated as a matter of course.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patient's social needs were also understood. Patients we spoke with told us they were enabled to manage their own health and care when they can, and to maintain independence.

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 in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.

## Are services caring?

- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 89% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format, as well as large font.
- To support patients who communicated using sign language, the practice had access to a service who provide British Sign Language (BSL) interpreters.

### **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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 137 patients as carers (1% of the practice list). There was a section on the practice's new patient registration forms where patients record whether they were or have a carer. The practice had a policy for carer identification which promoted referrals to adult care services for a carers assessment. The practice had appropriate referral forms, as well as agreement forms for carers to access a patient's personal details and/or copies of correspondence (with the patient's consent). The practices' patient information booklet also contained details of how patients could identify themselves as carers, as well as how they could self-refer themselves to other services. Written information was also available to direct carers to the various avenues of support available to them.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had developed a wide range of other services for patients. The practice objective was to place the patients at the heart of the services, rather than the patients being sent through the health care system to access the services. These services were provided by the practice either alone or in partnership with other providers such as the local hospital. Often the services were provided by GPs with special interests in the area of treatment concerned. The services were flexible, provided choice and helped to ensure continuity of care. All were provided in Borough Green Medical Practice. The services included, but were not confined to:

- Specialist ear, nose and throat (ENT) clinics, where patients could receive micro suction (a technique used to clear ear wax).
- Audiology (the treatment of hearing disorders, including evaluation of hearing function and rehabilitation of patients with hearing impairments). The practice had a booth on site for conducting hearing tests (which was funded by the Friends of the Surgery), as well as providing services to repair or replace hearing aids.
- Dermatology services (the treatment of hair, skin and nail disorders/diseases).
- Minor surgery, including vasectomy.

Referrals to these services could be patients from the practice or from other practices within the locality.

The practice recognised that involvement of other organisations was often integral to care. For example, the practice were in the process of conducting a Diagnostic Uncertainty Clinic pilot, in order to assess skin lesions. (Diagnostic uncertainty pertains to a clear diagnosis being achieved. Patients were therefore sent to the Diagnostic Uncertainty clinic for a confirmed diagnosis, rather than being sent to the hospital). The purpose of the pilot was to support the CCG and reduce the two week cancer wait. The clinics were provided by a GP partner who is a skin cancer

accredited surgeon. The aim of this pilot was to support the practices' philosophy of working closely with secondary care providers, as well as reducing referral rates in specialist areas of care and treatment.

- The practice offered early morning and late evening appointments on Mondays and Tuesday, for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities (including two wheelchairs), a hearing loop and translation services available.
- Telephone consultations were available.
- The practice was proactive in offering online services.
- The practice did not discriminate against age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation and people with complex needs. For example, those living with mental health illnesses, dementia or those with a learning disability. Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. For example, the use of a BSL translator to support patients who communicated using sign language.

### Access to the service

The practice was open between 7.30am to 1.00pm and 2.00pm to 7.30pm on Monday and Tuesday, 8.00am to 1.00pm and 2.00pm to 6.30pm on Wednesday, Thursday and Friday. In addition, appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

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

# Are services responsive to people's needs?

(for example, to feedback?)

- 73% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and the national average of 78%.
- 86% of patients said they could get through easily to the practice by phone compared to the CCG average of 76% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

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

## Listening and learning from concerns and complaints

It was easy for patients to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with. The practice took complaints and concerns seriously and responded to them in a timely way.

Improvements were made to the quality of care as a result of complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

- 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, posters displayed in the waiting room, summary leaflets available and through the practice's website.

We looked at seven complaints received in the last 12 months. Records demonstrated that the complaints were investigated, the complainants had received a response, the practice had learned from the complaints and had implemented appropriate changes. For example, following complaints about the attitude of staff, a protected learning time session had been held at the practice, in order to remind staff of policy and procedure in customer service skills.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The statement encompassed values such as acting on concerns about patient safety, commitment to continuous learning and delivering the best possible care for the individual patient.
- The practice had a robust strategy and a five year supporting business plan, which reflected the vision and values and were regularly monitored.

### 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.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- The arrangements for recording and managing risks, issues and implementing mitigating actions.
- The practice recognised that the effective governance of the dispensary was particularly important, as they dispensed medicines to approximately 5,600 patients. They had appointed a dispensary manager, two senior dispensers, four dispensers and a dispensary receptionist, in order to ensure the dispensary was managed and governed to a high standard. The dispensary had comprehensive systems and processes, which were clearly defined and embedded to ensure patient safety.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners 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. The partners encouraged a culture of openness and honesty. 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 management structure which included lead roles for the whole staff team (GPs, nursing team staff, dispensers and administrative staff) as well as heads of departments. Staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice.
- All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

# Are services well-led?

Good 

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

- The practice had a patient participation group (PPG) that the partnership viewed as their 'critical friend'.
- Patients were asked to provide feedback through the practice's website, through the PPG and through in-house surveys.
- The PPG met regularly and submitted proposals for improvements to the practice management team and the PPG members we spoke with, told us the practice responded positively to their proposals. For example, supporting the practice to review and management medicine waste. At the time of our visit the PPG were focussing on how to gather feedback from patients by other means. For example, social networking sites, which had been generated from a recent text message survey conducted by the PPG with an exceptional response rate. The PPG send out a quarterly newsletter. These are posted online, in the practice and are also emailed to patients who have requested a copy.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. The practice had gathered feedback from staff through staff surveys, staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was a very low staff turnover at the practice. Staff told us they came to the practice and have stayed because they felt included and integral in the running of the practice. As a means of recognising staff loyalty, the practice allowed staff to take a day off when it was their birthday.

## 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 a training practice and were committed and enthusiastic about their role in helping to train the next generation of GPs. All the staff were, to some degree, involved in the training of future GPs, nurses, dispensary, reception and administration staff. Additionally, the practice provided opportunities for phase three medical students from Kings College Hospital to gain experience and have an insight into working in general practice. Two of the GP partners provide ENT training/teaching sessions to West Kent CCG and neighbouring CCG areas and one partner gave presentations in relation to atrial fibrillation (AF – an irregular heart rhythm) at post-graduate centres.

Many of the partners were GPs with specialist interest (GPwSI - A GP with a special interest which supplements their role as a general practitioner by providing an additional service while still working in the community) accreditation.

The practice worked closely with colleagues at foundation trusts to facilitate research opportunities. The practice were taking part in a research project for Medway NHS Foundation Trust, in order to trial new remote technology in order to aid diagnosis and reduce referral rates.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <ul style="list-style-type: none"><li>The registered person did not do all that was reasonably practicable to assess the risk of, and prevent, detect and control the spread of, infections.</li></ul> <p>They had failed to take all appropriate action to address the issues identified in an infection control audit undertaken in July 2015.</p> <ul style="list-style-type: none"><li>The registered providers system to routinely check the equipment used in emergencies was not safe.</li></ul> <p>They had failed to ensure that oxygen masks used during a medical emergency were out of date.</p> <p>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>