

# Howell Surgery

## Quality Report

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

## Ratings

### Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Howell Surgery on 11 August 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.
- Dispensary staff undertook continuous professional development.

We saw an area of outstanding practice:

- The practice's performance in monitoring and maintaining the health of patients with long-term conditions, many of whom were older patients, in line with current best practice guidelines was significantly better than that achieved nationally or locally.

# Summary of findings

However there were areas where the provider needs to make improvements namely:

- Review the process for identifying people who were carers so as to make the carers register a truer reflection of the practice situation.

- Review their guidance as to what might constitute a significant event and ensure staff were aware of it.

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

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed that the practice's performance in monitoring and maintaining the health of patients with long-term conditions, in line with current best practice guidelines, was significantly better than that achieved nationally or locally. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice considerably higher than others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



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

The practice is rated as good for providing responsive services. It 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 national GP patient survey provided strong evidence that patients found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice results were considerably better than other

Good



# Summary of findings

practices locally and nationally. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received regular performance reviews and attended staff meetings and events.

**Good**



# 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 providing services to older patients. Data showed that the practice's performance in monitoring and maintaining the health of patients with long-term conditions, in line with current best practice guidelines, was significantly better than that achieved nationally or locally. It had been consistently achieved over the period of registration with the Care Quality Commission

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



### People with long term conditions

The practice is rated as outstanding for providing services to patients with long-term conditions. Data showed that the practice's performance in monitoring and maintaining the health of patients with long-term conditions, in line with current best practice guidelines, was significantly better than that achieved nationally or locally. It had been consistently achieved over the period of registration with the Care Quality Commission.

Nursing staff had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority and were followed up when they were discharged from hospital. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Outstanding



### 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 in line with national averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate. Appointments were available outside of school hours and the premises were suitable for children and babies. There was a midwife led ante-natal clinic at the practice each week.

Good



# Summary of findings

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

Good



The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the 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. There were evening surgeries two days each week for patients from this population group. 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.

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

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received one. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Outstanding



The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice participated in the enhanced service for patients with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. All the patients diagnosed with dementia had a care plans and had received a face to face review in the last twelve months. The practice's performance had above or equal to the local average over the last three years.

In 2014 92% of mental health patients had a care plan, agreed between them, their family and/or carers as appropriate and the GP. Between 2007 and 2013 100% of patients had had such a care plan.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary

## Summary of findings

organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. Some staff had received training on how to care for people with mental health needs and dementia.



# Summary of findings

## What people who use the service say

Results from the National GP Patient Survey July 2015 (from 121 responses which is equivalent to 2.4% of the patient list) demonstrated that the practice was performing considerably better than other practices locally and nationally. For example;

- 93% of respondents found it easy to get through to the surgery by phone compared with a local average of 75% and national average of 73%.
- 86% of respondents with a preferred GP usually got to see or speak to that GP compared with a local average of 72% and national average of 60%.
- 75% of respondents usually wait 15 minutes or less after their appointment time to be seen compared with a local average of 64% and national average of 65%.
- 94% say the last GP they saw or spoke to was good at explaining tests and treatments compared with a local average of 88% and national average of 86%.

There was no aspect of the GP patient survey where the practice's performance did not match or exceed both the local or national average performance.

As part of our inspection, we asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards and we spoke with six patients, together this is approximately 0.6% of the patients on the practice list.

The cards and the patients were uniformly positive about all the aspects of the service. They praised reception staff, nurses and GPs for their professional competence and caring attitude. Patients felt listened to. They said that they were treated with compassion. Some commented on the diagnostic skills of their GPs who had identified and acted upon problems quickly. This, the patients believed, had averted more serious consequences.

We received comments about the compassion that the staff showed in circumstances of bereavement. Several patients commented that the practice was an integral part of their village community. We spoke with the chair of the PPG who told us they felt the practice valued and nurtured their relationship which had been valuable in helping the community to understand some of the constraints under which the practice worked.

## Areas for improvement

### Action the service SHOULD take to improve

- Review the process for identifying people who were carers so as to make the carers register a truer reflection of the practice situation.
- Review their guidance as to what might constitute a significant event and ensure staff were aware of it.

## Outstanding practice

- The practice's performance in monitoring and maintaining the health of patients with long-term conditions, many of whom were older patients, in line with current best practice guidelines was significantly better than that achieved nationally or locally.

# Howell Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a pharmacy inspector.

## Background to Howell Surgery

Howell Surgery is a GP practice located in a rural area of Kent and provides care for approximately 5000 patients. The practice has somewhat more than the national average of patients over 65 years but the same as the national average of patients over 75 years and over 85 years. It is an area of low income deprivation. The Howell Surgery is a dispensing practice, as well as prescribing medicines, it has a pharmacy (the dispensary) where patients who live more than 1.6km from a community pharmacy can collect their medicines.

There are three GP partners, one female and two male, as well as one female salaried GP. There are two female practice nurses and a female healthcare assistant. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities and also offers enhanced services for example, extended hours. The practice is not a training practice.

Services are delivered from the central surgery at;

Howell Surgery,  
High Street,  
Brenchley,

Kent

TN12 7NQ

There is a branch surgery at;

Horsmonden Surgery,

Lamberhurst Road,

Horsmonden,

Kent

TN12 8LP

We did not visit the branch surgery

The practice has opted out of providing out-of-hours services to their own patients. Care is provided by Integrated Care 24. There is information available to patients on how to access out of hours care.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

This provider had not been inspected before and that was why we included them.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 11 August 2015. During our visit we spoke with a range of staff including GP partners, receptionists and administrators. We spoke with patients who used 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

# Are services safe?

## Our findings

### Safe track record and learning

There were systems for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was a process, which staff could access on the computer system, telling them how to report incidents. Staff did report events. Staff were aware of the processes for reporting events. Though there was guidance as to what might constitute a significant event it was out of date and staff were not aware of it. Therefore there was no common understanding amongst all staff of what constituted a significant event.

### Overview of safety systems and processes

The practice could demonstrate its safe track record through having risk management systems in place for safeguarding, health and safety including infection control, medication management and staffing.

There were arrangements to safeguard vulnerable adults and children from abuse that reflected relevant legislation and local requirements. All the GPs were trained to the appropriate level (level 3). There were policies which guided staff in safeguarding matters. There were notices directing staff on who to contact in order to report such matters. There was a practice lead (a GP) for safeguarding and staff knew who this was. GPs attended safeguarding meetings or provided reports if they were not able to do so. Staff demonstrated they understood their responsibilities and most had received training relevant to their role. The practice was identifying staff who needed refresher training and arranging for them to receive it.

There were notices in the waiting room and on the doors to consultation rooms, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones had received a disclosure and barring check (DBS). These 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 vulnerable adults.

There were processes for monitoring and managing risks to patient and staff safety. For example, there was a recent fire risk assessment, fire wardens had been appointed and fire evacuation drills carried out. There was a system governing security of the practice. Visitors were required to sign in and out using the dedicated book in reception. The staff

reception area in the waiting room was always occupied and the door shut to prevent unauthorised access. All electrical equipment was checked to ensure the equipment was safe to use. Clinical equipment was checked to ensure it was working properly and calibrated in accordance with the manufactures' instructions.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice to the practice infection control and carry out staff training. All the staff we spoke with knew who the lead was. Staff received induction training about infection control specific to their role and received annual updates. Infection control policy and procedures were available to staff, this helped enable them to plan and implement measures to mitigate the risks of infection. There were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Medicines in the treatment rooms, the dispensary and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure that medicines were kept at the required temperatures and which described the action to take in the event of a power failure. One refrigerator thermometer only recorded the current temperature. If there were a power failure which caused the temperature to rise above the safe levels, and the power and refrigerator temperature was restored for example over a weekend, the practice might be unaware of this. We discussed this with the practice and they have since taken measures to prevent this. Regular medication and prescribing reviews were carried out with the support of the clinical commissioning group help to ensure the practice was prescribing in line with best practice guidelines.

Records contained evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at staff files and saw that there was proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a policy that set out the standards for recruiting staff.

### Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and there were emergency medicines available in the treatment room. There were further emergency medicines in the GPs

## Are services safe?

individual bags. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency medicines we looked at were in date and checked regularly together with the emergency equipment. The practice had a defibrillator and medical oxygen with adult and children's masks.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The practice had two surgeries and much of the planning involved using the unaffected premises to reduce the impact of the event on the care to patients.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment and consent

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) guidelines and had systems to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and guidelines about other local practice such as local referral pathways. The practice used this information to develop how care and treatment was delivered to meet needs. For example, the practice implemented NICE guidance by using ambulatory blood pressure monitoring for patients with suspected hypertension (raised blood pressure).

Patients' consent to care and treatment was always obtained in accordance with legislation and guidance. The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded.

GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Specific consent forms were used for surgical procedures.

### Protecting and improving patient health

Patients who may be in need of extra support were identified by the practice. For example, as part of a national initiative to prevent unplanned admissions to hospital, the practice had identified the 2% of patients who were most vulnerable. Each of these had an individual care plan and a GP allocated to their care. Patients who were most in need of advice of matters such as a healthy diet, smoking and alcohol consumption were identified and sign posted to relevant services.

The practice's uptake for the cervical screening programme was 86.4%, which was better than the national average of 81.7%. The practice had consistently outperformed the national average by between 4% and 6% over the last decade.

Childhood immunisation rates were comparable to local and national averages. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 90% to 98% and five year olds from 84% to 96%.

### Coordinating patient care

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and other correspondence both electronically, by fax and by post. Staff knew their responsibilities in dealing with any issues arising from these communications. All 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.

There were regular meetings with other providers, for example there were monthly multi-disciplinary meetings to discuss the needs of complex patients, such as those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care and treatment were documented.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The results for the financial year ending March 2014 (the latest date for which results were available) were that the practice had attained a score of 99.6%.

Performance for patients with chronic obstructive pulmonary disease showed that 98% had received the annual review that was recommended. This placed the practice in the top 10% in the country. Similar figures for diabetic patients showed that again approximately 98% had been reviewed. This placed the practice in the top 5% in the country.

This performance in the monitoring of patients with long-term conditions was reflected across almost all disease areas where patients needed regular annual (or sometimes 15monthly) checks to meet the guidance for the best management of that condition. For example: for hypertension and chronic kidney disease 88% of patients

# Are services effective?

(for example, treatment is effective)

had been seen, this placed the practice in the top 35% in the country, for dementia all the patients had had a face to face review, for those with hypertension who were deemed to be less than active 288 out of 288 (100%), had had a recorded intervention in their condition and for hypothyroidism 97% had had the recommended test carried out in the last twelve months.

This performance had been sustained over the last few years the Howell surgery being often between 2% and 15% better than the results achieved nationally.

Only in two areas was the practice in the bottom half of the national results. In one case, mental health patients, the sample was too small to be significant because although in 2014 11 out of 12 or 92% of patients had been seen, and had a care plan, this placed the practice in the bottom half of achievement. It should be noted that from 2007 to 2013 the practice figure for the same outcome was 100% each year. The second example was asthma patients where 72% of patients had had an annual review. This was in line with the CCG average but 3.5% below the NHS England average.

The practice had conducted a number of audits. These had ranged from participating in medicines audits with the

local clinical commissioning group to audits of the quality of written instruction provided to patients on how and when to take their medicines. This latter audit had been repeated for a second cycle and an improvement shown. The percentage of instructions deemed to be inadequate or ambiguous had fallen from 6.9% to 4.8%.

## Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Records showed there was an overall training plan and mandatory training such as information governance, basic life support and infection prevention control had been completed by all staff. Where there were gaps, such as in safeguarding, the practice was aware of and were addressing them.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager. Dispensary staff undertook continuous professional development.



# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey. We spoke with patients and read the comment cards that patients had completed. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Patient confidentiality was respected. There was a private area where patients could talk to staff if they wished and there were notices telling patients about this facility. All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms and it was not possible to overhear what was being said in them. The rooms were, where necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

The survey results showed that;

- 94% said the GP was good at listening to them compared to the CCG average of 88% and national average of 86%. When asked the same question about nursing staff 98% said the nurses were good at listening to them compared to the CCG average of 94% and national average of 92%.
- 92% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%. When asked the same question about nursing staff 96% said the nurses were good at listening to them compared to the CCG average of 93% and national average of 91%.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%. When asked the same question

about nursing staff 98% said they had confidence and trust in the last nurse they saw were good at listening to them compared to the CCG average of 98% and national average of 97%.

- 97% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

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

The patient survey information showed patients responded positively to questions about their involvement in planning and making decisions about their care as well as treatment and generally rated the practice well in these areas. Data from the national patient survey showed that 86% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. The first result was in line with the national average, the second significantly above it. When asked the same questions about nursing staff the results were 92% and 88%, both slightly above the national average.

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

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access services such as those related to specific disabilities. There were notices in the patient waiting room and patient website that directed patients to support groups and organisations for carers. There was a protocol for staff to follow to help identify carers. Patients we spoke with, some of whom were also carers, said that the practice was very supportive of carers.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of people who were carers, however recording carers was an area where the practice felt it could improve.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice worked with the commissioners of services to improve outcomes for patients in the area. For example, the practice had recently agreed to provide enhanced services for patients with learning disabilities and there was training planned to improve the skills and knowledge of GPs in this speciality.

There was an active patient participation group (PPG) which met regularly and worked with the practice to improve services. For example the PPG had been effective in helping to educate patients about the proper use of the walk in surgeries so that this provision was not over used.

Services were planned and delivered to take into account the needs of different patient groups. There were extended hours surgeries for patients who could not easily attend during the normal working day. The practice was open until 7.15 pm on Mondays and 7pm on Wednesdays. There were longer appointments available for patients who needed them, for example patients with dementia or learning disability. There were home visits for patients who were unable to leave their home. There were toilet facilities for disabled patients.

### Access to the service

Results from the National GP Patient Survey from July 2015 showed that patients' satisfaction with opening hours was 76% and this is in line with both the CCG and national average. However 93% of respondents found it easy to get through to the practice by phone compared with the local

and national averages of 75% and 73% respectively. Also 94% were able to get an appointment to see or speak to someone the last time they tried compared with the local and national averages of 88% and 85% respectively.

The practice operated across two sites approximately two miles apart. The practice's opening hours across both were: 8am to 7.15pm on Mondays, 8am to 4pm on Tuesdays, 8am to 7pm on Wednesdays and 8am to 6.30pm Thursdays and Fridays. This included extended hours surgeries. There was a walk in surgery each day for patients who had problems that could not reasonably wait until the next available bookable appointment. There was a duty doctor each day should an emergency arise. Pre-bookable appointments could be made up to six weeks in advance.

### Listening and learning from concerns and complaints

There was a complaints policy which included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system in the form of leaflets, notices and material on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However, they felt that if they had to make a complaint they would be listened to and the matter acted upon.

We looked at the complaints reporting documents and log. We found that the practice had not received any formal complaints since it had been registered with the Care Quality Commission.

# 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 work in partnership with their patients and staff to provide the best primary care services possible, working within local and national governance, guidance and regulations. The practice had a mission statement which was to improve the health, well-being and lives of those people the practice cared for. Staff knew and understood the practice's ethos.

### Governance arrangements

The practice had a governance framework which supported the delivery of the strategy and good quality care. In support of this there were policies and procedures that guided staff. These were available to them on the desktop on any computer within the practice. We looked at some of these including recruitment, chaperoning, safeguarding, bereavement and complaints they were in date and reviewed when necessary. There was evidence that staff had read the policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GPs with responsibility for safeguarding and performance against the quality and framework (QOF). The QOF data for this practice showed it was performing in line with or often better than national standards. QOF data was regularly discussed at team meetings and there were plans to maintain and improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action was needed. These included audits of antibiotic prescribing, minor surgery and chronic kidney disease.

The practice had arrangements for identifying, recording and managing risks. These included fire, flood and damage to the building. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented. There had been regular fire evacuation drills.

The practice participated in the Dispensary Services Quality Scheme therefore the way in which medicines were dispensed and staff trained in the area of dispensing was subject to external scrutiny.

### Leadership, openness and transparency

The partners were visible in the practice and it was clear that there was an open culture within the practice. Staff had the opportunity and were happy to raise issues at team meetings. Staff told us that the GPs and management were approachable and took the time to listen to staff.

There were regular practice meetings. Minutes were kept and there was a structured agenda. Topics such as significant events, training and changes to practice policies were discussed. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice. Staff told us of occasions when they had made a suggestion at a staff meeting; it was accepted and they were empowered to research, source and purchase the items concerned.

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

The practice encouraged and valued feedback from patients. There were suggestions boxes and patients were asked to provide feedback through the practice's website. The practice gathered feedback from patients through the patient participation group (PPG) and through surveys such as the National GP Patient Survey. In collaboration with the PPG a newsletter had been published and circulated through community outlets. An evening, hosted by the PPG, invited patients to a talk by diabetic and end of life care charities. PPG members took part in a village event where they were able to tell patients about the PPG and the practice.

### Innovation

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Records showed that regular appraisals had taken place which included a personal development plan. Staff were very positive about the practice's commitment to staff development. For example, each staff member had a personal planner of courses that needed to be done in the forthcoming year.

The practice was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example one of the GPs was a GP with a Special Interest (GPwSI) in minor surgery (A GPwSI is a formal accreditation that reflects the GP's expertise in a specific area that has been achieved through a range of activities, such as

## Are services well-led?

Good 

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

education, research and involvement with service development and management). The practice was able to offer this service to patients from surrounding practices as well as their own.