St James' 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St James Surgery on 10 January 2017. 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 the experience, and had been trained to provide them with the skills and knowledge, 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.
- 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.

We saw an area of outstanding practice:

- The practice had two mobile telephone apps to improve communication with patients, this had

Summary of findings

impacted positively, particularly on young people and working age patients. It had also helped to reduce the number of patients who failed to attend their appointments by approximately 50%.

The area where the provider should make improvement is:

- Continue to identify patients who are also carers to help ensure they are offered appropriate support.

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?

Good

The practice is rated as good 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.
- The clinical pharmacist made a significant contribution to safe medicines' management for example in checking the notes of patients discharged from hospital to help ensure that any changes to medication were safe.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

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. There was a marked emphasis on staff development, supported by the practice across clinical, managerial and administrative roles.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.

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.
- Patients at the end of their life, and their carers, had dedicated telephone numbers so that they could contact the practice in case of emergency.

Are services responsive to people's needs?

Good

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. For example initiating insulin treatment for diabetes.
- 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.
- 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.
- The practice was part of a Prime Minister's challenge fund project which provided patients with access to a GP from 8am to 8pm seven days a week at a the local community hospital.

Are services well-led?

Good

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.

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 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 help 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.

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

Good

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.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Information and correspondence was available in large print if requested
- There was close working with nearby care homes and a local charity, this included referring family members for respite care when necessary.

People with long term conditions

Good

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.
- There are 11 indicators for the management of diabetes, these can be aggregated. The aggregated practice score for diabetes related indicators was 89% compared with the clinical commissioning group (CCG) average of 93% and the national average of 90%. The percentage of patients on the diabetes register, with a record of a foot examination and a risk classification within the proceeding twelve months was 85% compared to a national average of 89%.
- 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.
- The clinical pharmacist worked with these patients and the GP to help ensure a consistent supply of medicines and “rescue” medicines. (these are medicines used for quick relief of symptoms, such as wheezing in asthma

Summary of findings

Families, children and young people

Good

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 Accident and Emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- The practice cared for the pupils at a local state boarding school. We saw that services were tailored to help meet their needs. There was a branch of the patient participation group planned specifically for school. There was a GP surgery daily at the school.
- The practice had two mobile telephone apps to improve communication with patients, this had impacted positively, particularly on young people. It had also helped to reduce the number of patients who failed to attend their appointments by approximately 50%.
- The practice's uptake for the cervical screening programme was 85%, compared with the CCG average of 82% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

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.
- 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.
- The practice had two mobile telephone apps to improve communication with patients, this had impacted positively, particularly on working age patients. It had also helped to reduce the number of patients who failed to attend their appointments by approximately 50%.

Summary of findings

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 including homeless people and those with a learning disability. There was cooperative working with the local learning disability nurse.
- The practice kept a record of patients on the palliative care register who were most likely to have immediate need of care. This was checked weekly to help ensure these patients had the right medicines in the right quantity for any eventuality. The patients and their carers had dedicated telephone numbers so that they could contact the practice in case of emergency.
- 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.
- 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)

Good

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

- Eighty seven per cent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, compared with to the national average of 84%.
- the percentage of patients with schizophrenia and other psychoses who had had a comprehensive care plan in the preceding 12 months, agreed between individuals, their family and/or carers was 98%. This was markedly better than the CCG and the national average at 88%
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system to follow up patients who had attended A&E where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and fifty three survey forms were distributed and 123 were returned. This represented one percent of the practice's patient list.

- 93% found it easy to get through to the practice by telephone compared with the clinical commissioning group (CCG) average of 71% and the national average of 73%.
- 87% were able to get an appointment to see or speak with someone the last time they tried compared with the CCG average of 86% and the national average of 85%.
- 95% described their overall experience of the practice as good compared to the CCG average of 84% and the national average of 85%.
- 81% said they would recommend the practice to someone new to the area compared to the CCG average of 76% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards. All were positive about the care received. Patients mentioned that they were treated with dignity and respect. They felt the quality of clinical care and diagnosis was high. One comment expressed regret that there was no regular female GP.

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

Areas for improvement

Action the service SHOULD take to improve

Continue to identify patients who are also carers to help ensure they are offered appropriate support.

Outstanding practice

The practice had two mobile telephone apps to improve communication with patients, this had impacted positively, particularly on young people and working age patients. It had also helped to reduce the number of patients who failed to attend their appointments by approximately 50%.

St James' Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St James' Surgery

St James Surgery is a GP practice located in the town of Dover, Kent. It provides care for approximately 8200 patients.

There are three GP partners and a salaried GP. All are male. There are four nurses and three healthcare assistant all female. There is a practice manager and administrative and reception staff.

The demographics of the population the practice serves is generally similar to the national average although there are fewer people aged between 20 and 49 years than nationally. The practice cares for the pupils at a local state boarding school and therefore has many more patients between the ages of 10 and 19 than the national average. The majority of the patients describe themselves as white British. Income deprivation is marginally below the national average though there are pockets of quite severe urban deprivation in the practice area. Unemployment is about half the national average.

The practice has a general medical services contract with NHS England for delivering primary care services to local communities. The practice offers a full range of primary medical services. The practice is a training practice (training practices have GP trainees and foundation year 2 doctors).

The practice is open between 7.30am and 6.30pm Monday to Friday. There are evening surgeries until 8pm on Wednesdays and Thursdays. GPs and nurses varied their appointment times so appointments might be at any time when the practice was open.

The surgery building has three stories with consulting, treatment rooms and administration rooms on the ground floor. It is accessible to patients in wheelchairs or those with pushchairs

Services are provided from

St James Surgery,

2 Harold St,

Dover

CT16 1SF

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

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice 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 including GPs, nurses, administration and reception staff. We spoke with patients who used the service.
- We saw how patients were looked after both in the reception and over the telephone and talked with carers and/or family members
- Reviewed an anonymised sample of treatment records of patients.
- Reviewed comment cards where patients had 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.

Good

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.

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, a patient had become ill in the practice car park and had needed immediate attention. The situation was dealt with and the patient cared for. The practice reviewed how it had managed the event and made changes to processes including; placing gloves in the emergency kit, rewriting instructions to staff to help ensure that oxygen and the first aid kit were taken to all incidents in the future and changing how the emergency medicines were stored.
- Another incident had involved how the local district general hospital had managed a patient's referral and we saw that the practice had put their concerns to the hospital in writing and had received a response.

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. Nurses to safeguarding level two and other staff to levels appropriate to their role.
- Notices in the waiting, consultation and treatment rooms 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. The premises were clean and tidy. One of the practice nurses was the infection control clinical lead. They had had an initial course and recent updates in infection prevention control. They attended quarterly meetings 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. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. These included replacing cupboards on the minor operations suite to reduce the amount of high dust collected and updating the sharps bins (sharps bins are specially designed rigid boxes with lids in which to dispose of contaminated sharps such as hypodermic needles).
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice was part of an NHS England trial to use clinically trained pharmacists in general practice to help staff manage medicines and help to keep patients safe. We saw several examples of this work in progress. This

included a new process to help resolve medicines supply issues. The pharmacist had developed a protocol to manage certain medicines where regular testing of patients' blood was particularly important. The pharmacist also checked the notes of patients discharged from hospital to help ensure that any changes to their medication were safely managed.

- The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- 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. Stickers were fixed to equipment to identify that it had been checked (or calibrated) and to notify the practice when retesting was due. The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota 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 with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- 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.

Good

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. For example the practice provided 24-hour ambulatory blood pressure monitoring as a means of confirming a diagnosis of primary hypertension as recommended by NICE clinical guidance number 127. We saw that there were written copies of NICE guidance, such as those relating to certain aspects of diabetes management, on the nurses notice board in the room where such patients were routinely seen.
- An example of national best practice was provided by the use of the Cardiff health check for patients with learning disability.

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 (2015-2016) results showed the practice achieved 97% of the total number of points available, with 11% exception reporting. (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). The clinical commissioning group (CCG) and national exception reporting rate was 10%

The practice was not an outlier for any QOF (or other national) clinical targets.

The most recent published results showed:

- There are 11 indicators for the management of diabetes, these can be aggregated. The aggregated practice score for diabetes related indicators was 89% compared with the CCG average of 93% and the national average of 90%.
- The percentage of patients on the diabetes register, with a record of a foot examination and a risk classification within the preceding 12 months was 85% compared to a national average of 89%.
- Eighty seven percent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, compared with to the national average of 84%.
- The percentage of patients with chronic obstructive pulmonary disease ((COPD) - a long term respiratory condition) having an annual check by a healthcare professional was 91%. This was better than the CCG and national averages at 90%.
- Performance for mental health related indicators was better than the CCG and national average. For example, the percentage of patients with schizophrenia and other psychoses who had had a comprehensive care plan in the preceding 12 months, agreed between individuals, their family and/or carers was 98%. The CCG and the national average was 88%.

There was evidence of quality improvement including clinical audit.

- There had been two clinical audits completed in the last two years where improvements had been undertaken and completed. For example the practice had used cycles of audits of the prescribing of certain antibiotics and had reduced the use of them to amongst the lowest in the CCG.
- The practice compared their prevalence (the number of cases per thousand patients) of coronary artery disease with practices with a similar type of population and felt that it was too low. The GPs audited the information and found a number of issues that included incorrect coding of the disease. This was discussed at a clinical meeting and, as a result of improvements to practise the prevalence rose. Therefore approximately 20 patients were offered interventions for the disease who might otherwise not have been identified.
- The practice participated in local audits, national benchmarking, accreditation, and peer review.

Good

Are services effective?

(for example, treatment is effective)

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, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions there had been training in initiating insulin treatment and managing patients with COPD.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Staff appraisal was effective. We saw examples of staff seeking to develop, such as becoming a minor injuries nurse or healthcare assistant and being supported to do so. This also applied to administrative staff who were supported and encouraged to obtain relevant managerial qualifications.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan 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.

There was cooperative working with the local learning disability nurse. We saw examples where the practice had not been able to contact certain patients and had been able to use the nurse as means opening a channel of communication. The nurse had also been able to advise the practice about particular patients' problems. For example a patient who would come to the practice but was upset by coming into the building was seen, privately, in the car park.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition or those requiring advice on their diet, smoking and alcohol consumption were signposted to the relevant services.

Good

Are services effective?

(for example, treatment is effective)

The practice had put considerable effort into improving their rate for cervical screening over the last three years. They encouraged uptake of the screening programme by using information in different languages, making available special leaflets for those with a learning disability and they ensured a female sample taker was available. As a result they had gone from being in the bottom quarter of practices in the country (2013) to the top fifth (2016). The practice's uptake for the cervical screening programme was 85%, compared with the CCG average of 82% and the national average of 81%. The practice telephoned patients who did not attend for their cervical screening test to remind them of its importance.

The practice also encouraged its patients to participate in national screening programmes for bowel and breast cancer screening. For example, 74% of women aged between 50 and 70 had attended screening for breast cancer which was higher than the national average of 72%. Bowel cancer screening was similar to local and national averages, at 60% compared with the CCG average of 60% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to the national averages. There are four areas where childhood immunisations are measured, each has a target of 90%. The practice achieved the target in three out of four areas, in the remaining area they scored 86%. These measures can be aggregated and scored out of 10. The practice scored 9.2 the national average was 9.1.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- 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 that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room.

All of the 29 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

Results from the national GP patient survey 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:

- 93% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and national average of 89%. When asked the same question about nursing staff the results were 96% compared to the CCG average of 93% and national average of 91%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%. When asked the same question about nursing staff the results were 100% compared to the CCG and national average of 97%.
- 88% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 85%. When asked the same question about nursing staff the results were 92%compared to the CCG average of 92% and national average of 91%.
- 96% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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 generally higher than local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%. When asked the same question about nursing staff the results were 94%compared to the CCG average of 91% and national average of 90%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 82%. When asked the same question about nursing staff the results were 85%compared to the CCG average of 87% and 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.
- The clinical pharmacist had ensured that high quality leaflets, explaining the impact of various medicines in

lay terms, were available to patients. The pharmacist was also available to help patients, particularly those on multiple medicines, about how to make informed decisions about their care.

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 34 patients as carers which was less than one per cent of the practice list. The practice has, since the inspection, identified some technical errors on the coding of patients' records which contributed to this. However the practice acknowledged that this percentage was low.
- Written information was available to direct carers to the various avenues of support available to them.

The practice maintained a palliative care register, from that register they kept a record of patients who were most likely to be in immediate need. This was checked each week to help ensure the right, and sufficient, medicines were available. The families or carers of these patients had a direct telephone number to practice so that any urgent needs could be discussed and addressed. 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.

Good

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. Services included in house "Doppler" assessment (to detect abnormal flow within blood vessels, indicative of clotting), 24 hour blood pressure monitoring, minor surgery and physiotherapy.

- The practice offered a 'Commuter's Clinic' on Wednesday evenings until 7.30pm and between 7.30am and 8am every Thursday and Friday, for working patients who could not attend during normal opening hours.
- There was a nurse home visiting service for annual and regular reviews such as for diabetes and asthma and influenza vaccinations for housebound patients.
- The practice hosted a counselling service.
- There was no regular female GP at the practice, the practice had tried to recruit one. The practice had a close working relationship with a nearby practice to which patients were referred if they wanted to see a female GP.
- There were longer appointments, available at quiet times, for patients with a learning disability and these conducted at the patient's home if this was necessary.
- 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, a hearing loop and translation services.
- The practice, it worked with a local charity to help its patients and carers receive respite care.

Access to the service

The practice was open between 7.30am and 6.30pm Monday to Friday. Extended hours appointments were between 7.30am and 8am every day and from 6.30pm to 8pm on Wednesdays and Thursdays. Appointments could be booked up to four weeks in advance and there were urgent appointments available on the day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was better, sometimes significantly so, than local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared with the CCG average of 79% and the national average of 76%.
- 93% found it easy to get through to the practice by telephone compared with the CCG average of 71% and the national average of 73%.

The practice was part of a Prime Minister's challenge fund project which provided patients with access to a GP from 8am to 8pm seven days a week at a the local community hospital. The GP had electronic access to the patients' notes.

People told us on the day of the inspection that they were able to get appointments when they needed them. For example we saw that a patient calling into the practice at 10.10am was offered an appointment with a nurse at 3.40pm that day. The wait for patients wanting to see their own doctor was, subject to leave or other absences, approximately eight days.

The practice had a system to assess:

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

Cases were referred to the duty doctor who contacted the patient by telephone to assess their needs. There was a paramedic practitioner home visiting service. Paramedics would only visit when and if the GP felt the case was appropriate, or if an urgent visit was required and no GP was immediately available. We were told that there was strong support for the service from the public and GPs and that when admission to accident and emergency was necessary having paramedics improved the speed and process of admission.

Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. .

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had an effective system for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance.

- 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, in the practice leaflet, on posters within the practice and on the practice website.

We looked at the ten complaints received during the previous financial year. We saw that they had been dealt with in a timely fashion. Where there were delays, for example where the practice was waiting for another agency to respond as part of the investigation, the complainant was kept informed. Replies were open and honest and addressed the issues raised by the complainants. Lessons were learnt from individual concerns and complaints as well as from analysis of trends.

Several complaints had revolved around the terminology used by clinical staff, for example different clinical staff using different terms to describe the same thing, leading to confusion for the patient. This had been discussed in clinical meetings and staff agreed to focus on how matters were explained to patients in the future. It was accepted that this kind of communication problem was impossible to solve completely but the practice noted that no complaints of that nature had been received since. GPs wrote to patients when this was necessary and we saw that they took great care to ensure that all the issues, raised by the complainants, were fully addressed.

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. The statement included;

- Commitment to provide a high standard of clinical care, with patients' choice central to practice ethos and treating all individuals with respect
- Working collaboratively with other health, social and charitable organisations.
- Working as a team to improve and supporting staff development.
- The staff values had been discussed at a full staff meeting which included suggestions from the patient participation group. Various mission statements had been proposed, and staff had voted for their choice, which had come from one of the administrative staff and was "our patients, our priority".
- Staff knew and understood the values.
- The practice had a robust strategy and supporting business plans 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.
- Leading staff members had responsibility for key roles such as, human resources, quality, safety and finance.
- The practice had a comprehensive understanding of its performance. For example the partners had recognised that QOF performance had been declining and appointed a staff member with responsibility for this.
- Responsibilities were not confined to very senior staff or partners. For example a member of the administrative staff had responsibility for QOF performance. They told us they were empowered to raise any failing, by any staff, to carry out QOF related tasks and had done so. QOF performance had shown a marked improvement in the last two years and was now above the local and national averages for most data related to long term conditions with annual or regular reviews.
- Practice specific policies were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. This was a targeted approach, for example the practice felt that their prevalence of coronary artery disease was too low and carried out an audit. This led to some improvements and whilst it remained low the practice had satisfied themselves that all staff were alert to the need to identify cases of the disease.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

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. We saw that 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 training for all staff on communicating with patients about notifiable safety incidents.
- The partners encouraged a culture of openness and honesty.

When things went wrong with care or 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.

The leadership structure was clear and staff felt supported by management.

- There were 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

Are services well-led?

Good

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

involved in discussions about how to run and develop the practice. Staff we spoke with said that this was a team responsibility. Examples of accepted suggestions included changes to the car parking arrangements, the use of portable air conditioning units and installing chairs with arms in some areas of the practice. Changes to clinical practice included carrying out minor operations in the mornings only so as to reduce the risk of medically acquired infection through cross contamination.

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.

- The practice had gathered feedback from patients through the patient participation group (PPG) as well as through surveys and complaints received. The PPG met regularly approximately six times a year. The PPG said that they had influenced change in the practice. Examples given included strong support for the use of a pharmacist in the practice, changes to the reception area and signage within the practice.
- The practice looked after the pupils at a local state boarding school and was setting up a PPG solely within the school. All the work for this had been completed and it had only been delayed because of changes within the school management.

Continuous improvement

The practice was an accredited training practice. As a training practice, it was subject to scrutiny and inspection by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. Therefore GPs' communication and clinical skills were regularly under review.

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- For example it was part of a trial with NHS England to use clinical pharmacists within the practice. This had been of direct and immediate benefit to the patients. We saw cases where the pharmacist had intervened after patients discharged from hospital had had their medicines changed in ways that were inappropriate or where the consequences of the changes had not been properly explained to them.
- Many staff told about the support they received for educational development. This ranged from extending typing skills, through management and employment law courses to clinical areas such as nurse prescribing and minor injuries training.