# The Orchard Practice

## 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 The Orchard Practice on 7 October 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, responsive and safe services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia).

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, with the exception of those relating to recruitment checks.
- 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.

# Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had successfully helped 56 patients to stop smoking within a one year period.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should

- Maintain staff records so that the correct information is recorded.

**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. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Staff were aware of the policies and procedures in place for reporting concerns and safeguarding of vulnerable adults and children. Staff had received training in safeguarding children and adults. The practice had undertaken an analysis of significant events in the last 12 months where learning points and actions had been recorded. Medicines kept on the premises at were stored appropriately and securely. Staff were aware of emergency procedures and knew where the resuscitation equipment was kept.

We saw that all the doctors and nurses had received the appropriate checks Disclosure and Barring Service (DBS) (previously known as Criminal Records Bureau (CRB) to help ensure that people who used the service were protected. The practice offered a chaperone option where a member of staff would be available to accompany patients during intimate examinations at their request (or at the instigation of the clinician involved) and look after a baby or child while their mother was being examined by a GP or nurse. We saw risk assessments for reception staff that confirmed that they had received chaperone training, however, none of the reception staff who also carried out chaperone duties had had a DBS check. All members of staff who undertake a chaperone role should have had a Disclosure and Barring Service (DBS) check. After the inspection and our discussion with the practice, the partners at the practice have made the decision not to use reception staff for chaperoning.

We also found that there was no evidence on the records for nursing staff that their professional registration was up to date. During the inspection, the practice manager checked the registrations on line and printed copies for the nurses' records.

**Are services effective?**

Good

The practice is rated as good for effective. We found that the practice had systems in place to ensure that they could effectively respond to the needs of the patients accessing the surgery. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed

# Summary of findings

that it was performing in line with the national average. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to ensure continuity of care.

**Are services caring?**

Good

The practice is rated as good for caring. The practice carried out regular satisfaction surveys to capture patients' views. The patients we spoke with and the feedback cards we reviewed were very positive about the care patients received. Patients told us that staff were kind, caring and respectful throughout the episode of care that they had received.

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

Good

The practice is rated as good for responsive. There were mechanisms to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided and they were listened to and actions had been taken to make changes where practicable to do so.

**Are services well-led?**

Good

The practice is rated as good for well-led. Staff told us that they felt supported and that the practice was well-led. There were regular team meetings to ensure that information was cascaded to all staff team members. This included learning from incidents and any changes to practice across the organisation. There was a complaints policy and procedure in place as well as a process for escalating incidents to senior managers. All complaints and incidents were reviewed through the clinical meetings.

# 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 proactively identified patients and their carers who may have needed on-going support. The practice provided visits for those who were housebound or too ill to visit the surgery. The practice GPs made regular visits to four local care homes. The practice offered influenza and pneumonia vaccinations for patients over 65 years of age. Patients of 75 years have a named GP in line with national recommendations, however, they could have an annual health check with the practice nurse

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions.The practice nurses treated minor illnesses and monitored chronic diseases for example, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and heart disease. The practice provided diabetic, weight management and asthma clinics that were run by the nurses in conjunction with the doctors. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. A team of health visitors covered the practice area and looked after new mothers and children. When looking at immunisation rates, overall the practice were higher for all standard childhood immunisations when compared to national average and the area clinical commissioning group (CCG). For example, for the four in one booster vaccine given to pre-school children known as DTaP/IPV, the practice had achieved 95.0% compared to the CCG rate of 88.7%. We saw evidence that young people were treated respectfully by practice staff and in an age appropriate way.

Pregnant patients are referred to the local NHS hospital where antenatal care is given by midwives in the various children's centres. Baby clinics were held weekly (six week checks – with GP) for child development checks and allowed an opportunity to discuss other problems. This clinic was run by two of the practice GPs for child development checks and allowed for opportunities to discuss other problems for example sleeping, feeding and child health worries with the doctor. A full range of family planning services were offered by the practice and a full range of contraception with the exception of  insertion of coils.

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**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 practice offered extended hours outside of their contracted hours. The practice was open from 8am until 6.30 pm Monday to Friday and from 7.45 am until noon on Saturdays for pre-booked appointments. This was primarily for patients who found it difficult to attend during working hours.

Medical examinations for special purposes, for example, life insurance, driving medicals and pre-employment were offered by the practice and usually took place during normal surgery hours. A cost would be incurred for these services. The practice nurses were available to offer medical advice regarding travel and to vaccinate where appropriate.

During the flu vaccination period between September and January each year the practice was flexible and offered patients the opportunity to have their vaccination on a Saturday.

All smokers were offered smoking cessation advice. The practice had successfully helped 56 patients to stop smoking within a one year period.

**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 told us it did not have specific groups of patients in vulnerable circumstances such as travellers, homeless people or asylum seekers. However, staff had access to interpreters via the internet and information in different languages. In addition, there was an agreed policy that the practice would use its own address for anyone that was homeless to ensure they were able to receive appropriate care and support. There was access to a loop for people who had a hearing impairment and, if required, they would contact a local service for signing for those with a hearing impairment.

The practice had a learning disability register which had recently been updated after liaising with the learning disability team. Patients with learning disabilities (excluding children) were assessed and an annual review was undertaken of their physical, psychological and social circumstances. We saw that there was disabled access throughout the surgery, however, the counter at the reception was high. Therefore, patients in wheelchairs may find it difficult to communicate with reception staff.

# Summary of findings

One GP told us that they worked with community services for substance misuse and that they had links with a good outreach dementia service.

**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). Patients and those close to them were supported to receive emotional support from suitably trained staff if they needed it. Counsellors were available at the practice and patients were referred to them by the doctors. The practice also kept an up to date list of telephone numbers for counselling services and the crisis team. We saw that the practice had posters in the waiting area signposting patients for information on dementia and counselling.

We were told that the practice had links with the local hospice and patients for bereavement counselling were supported to self refer. We were told that the practice had links with counsellors and there was one who specialised in the care of children. We saw that the practice had received feedback from counsellors and looked at letters from various patients who were helped.

# Summary of findings

## What people who use the service say

During our inspection we spoke with eight patients. Patients were complimentary about the care they received and told us that the staff were helpful, knowledgeable and they felt safe and well cared for. However, a few patients complained that there was a long wait for appointments if they wished to see their own doctor.

We looked at 44 completed comment cards. The majority of comments we received were positive. Some patients said they had used the practice for a long period of time and they were satisfied with their care. Patients said the staff always did their best and the premises were hygienic and safe. There was a comments box in the main reception to encourage patient feedback. We saw that there were cards and letters of thanks from patients, their families and carers to the staff.

## Areas for improvement

**Action the service SHOULD take to improve**

- Maintain staff records so that the correct information is recorded.

## Outstanding practice

- The practice had successfully helped 56 patients to stop smoking within a one year period.

# The Orchard Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

The inspection team was led by a Care Quality Commission inspector and a GP specialist advisor.

## Background to The Orchard Practice

The Orchard Practice is housed in a purpose-built health centre, along with three other practices, all using the ground floor of the building. Wheelchair access to the building is through the main door and the first floor can be reached by a lift where patients can access community services such as speech and language therapy, podiatry and dentists. The practice had a list of 8,000 patients and is a training practice. The practice served an area with average deprivation and a higher than the national average of the practice population had depression.

The practice has three full time partners (one male and two female), one full time salaried GP (female) and currently has two registrars. There are three female nurses and one female healthcare assistant/phlebotomist, and one receptionist/phlebotomist.

The practice is open from 8.00am to 6.30pm Monday to Friday with some Saturday mornings as part of their extended opening. Surgeries start at 8.10am for GPs until 10.50am after which time there are extra appointments for emergency patients. The afternoon surgery begins at 2.50pm until 4.50pm. There are also appointments at 5pm available for medical emergencies only. This allows the practice to respond to patients unable to get an appointment that need urgent attention. Appointments can be pre-booked and the practice also offers on the day appointments to patients. The practice offers an out of hours service for emergencies and has ensured that their system for contacting the duty doctors is easy to follow, reliable and effective.

The practice's nursing team worked in a similar way to the GPs with their surgery times also having some appointments set aside for emergencies. The practice nurses will treat minor illnesses and monitor chronic diseases for example, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and heart disease. The practice nurses' roles include health promotion, wound care, travel and routine vaccinations, cervical smears and ear syringing. The health care assistant helps the practice nurses.

## 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.

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.

# Detailed findings

## How we carried out this inspection

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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the local Healthwatch, clinical commissioning group and NHS England to share what they knew. We inspected the practice as part of our new inspection programme for GP services. We carried out an announced visit on 07 October 2014. We spoke with staff and patients who used the practice. We carried out a number of interviews with senior staff for example four doctors, a practice manager, a practice nurse, a healthcare assistant and one receptionist/phlebotomist. During the inspection we reviewed policies and procedures that had been put in place so that the practice could monitor the quality of the service they provided. We observed how staff handled calls for repeat prescriptions or appointments. Comment cards were given to the practice prior to the inspection to assess patients views about the care they received and some stakeholders were contacted as part of the inspection process.

Good

# Are services safe?

## Our findings

### Safe track record

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last three years. The practice had managed these consistently over time and so could evidence a safe track record over the long term. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments received from patients.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice had a serious incident policy in place. We discussed significant event reporting with the practice manager. They told us that staff completed a form and discussed the incident with them. The incident would then be discussed at partnership and staff meetings. We looked at minutes of clinical governance meetings and saw that discussions of significant events were a regular item on the agenda, where learning points and actions had been taken and recorded.

### Reliable safety systems and processes including safeguarding

The practice had policies and procedures for safeguarding vulnerable adults and children which included contact details of the local safeguarding teams. A named GP was identified as the safeguarding lead. She told us about recent children's referral and adult referral she had made to social services. The GP told us that she had been to a child protection case conference regarding substance misuse and an adoption issue. The GPs had undertaken level three safeguarding training. One GP told us about a situation where they were made aware of domestic violence and social services were contacted.

Staff we spoke with had received safeguarding training and knew how to report any concerns. There was a whistle-blowing policy. Staff we spoke with were able to tell us how they would recognise and report abuse. One member of the reception team told us about a situation that had arisen that they had reported to the doctors. The practice escalated the information to social services who undertook an investigation.

We saw that all the doctors and nurses had received the appropriate checks Disclosure and Barring Service (DBS) to help ensure that people who used the service were protected. The practice offered a chaperone service where a member of staff would be available to accompany patients during examinations at their request (or at the instigation of the clinician involved). On the day of our inspection we saw risk assessments for reception staff that confirmed that they had received chaperone training, however, none of the reception staff who also carried out chaperone duties had had a DBS check to ensure that they were of good character. After the inspection and our discussion with the practice, the partners at the practice have made the decision not to use reception staff for chaperoning.

### Medicines Management

The practice stored vaccines and had medicines for emergency situations. We saw that the practice had in place and followed guidelines for maintaining the vaccine cold chain so that the viability of vaccinations could be assured. We found that medicines and vaccines were stored securely in an area accessed only by designated staff. There were processes in place for checking that all medicines and vaccines were accounted for. We saw that the appropriate temperature checks for the refrigerators used to store medicines had been carried out and all medicines and vaccines were stored at the correct temperature. The nurses administered vaccines using directions that had been produced in line with legal requirements. We saw evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Patients requiring repeat prescriptions were able to do so either on line, in writing or put the repeat prescription in the post box in reception. The practice did not routinely take prescription requests over the telephone, however, they did for certain patients with known difficulties or if a patient was going to run out of medication imminently. The practice had arrangements with neighbouring pharmacies who operated a collection service on the patient's behalf.

Good

# Are services safe?

## Cleanliness & Infection Control

We saw that the practice had completed an infection control audit that had identified the environmental issues and that carpets and desks were not in a good state of repair. Plaster was flaking off the walls and there were missing tiles on the walls in the staff toilets. The audit also identified that some work surfaces around clinical hand wash basins and floors were not impervious and sealed. The practice had applied to NHS England for a grant towards the costs of refurbishment and were waiting for a meeting to be held to decide the outcome.

The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with personal protective equipment including a range of disposable gloves, aprons and coverings. We saw that antibacterial hand wash, gel and paper towels were available throughout the practice for staff and patients. We saw that all instruments were single use only.

A practice nurse was the infection control lead. Staff we spoke with told us they had been trained in infection control and the staff training records confirmed this.

The practice had an Infection Control Policy that outlined the procedures for staff to follow to ensure that the Code of Practice for the Prevention and Control of Health Care Associated Infections was implemented. The code sets out the standards and criteria to guide NHS organisations in planning and implementing infection control measures.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company.

We saw that on 14 June 2014 maintenance of the building water system was checked for Legionella (a germ found in the environment which can contaminate water systems in buildings), descaling and general service.

## Equipment

Nursing staff told us that they had adequate equipment to enable them to carry out diagnostic examinations and treatment. This included equipment and medicines to ensure that staff were able to provide the appropriate assessment and treatment to patients. We saw records that confirmed that portable appliance testing (PAT) had been undertaken.

## Staffing & Recruitment

Records we looked at for all the doctors and nurses contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical staff.

We also found that there was no evidence on the records for nursing staff that their professional registration was up to date. During the inspection, the practice manager checked the registrations on line and printed copies for the nurses' records.

We spoke with the practice manager about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. They showed us the systems they used to arrange rotas for all the different staffing groups to ensure they had enough staff on duty to meet the needs of patients.

## Monitoring Safety & Responding to Risk

There were processes in place and meetings to discuss governance issues relating to safety. The practice had developed some systems to respond to identified risks. For example, staff we spoke with described the procedure for dealing with safety alerts from outside agencies to keep the practice up-to-date with failures in equipment, processes, procedures and substances.

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and the environment, for example, service contracts were in place with specialist contractors in relation to fire safety and electrical testing.

## Arrangements to deal with emergencies and major incidents

We saw that the practice had a robust business continuity plan. This included all essential elements including loss of site, loss of power, loss of IT, staffing and what to do and who to contact in each scenario. The practice had arrangements with a local medical centre that in the event of an evacuation, it would be possible to set up limited facilities at their premises and support and advice obtained from the relevant bodies.

Good

# Are services safe?

The practice had ensured reception staff had protocols in place to summon the emergency services if required. There were emergency treatment arrangements, including emergency medicines, a defibrillator and access to medical oxygen. Records showed that the emergency medicines were checked on a monthly basis.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Management, monitoring and improving outcomes for people

The practice was managed effectively. We found that the practice had systems in place to ensure that they could effectively respond to the needs of the patients accessing the surgery. The practice used Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that it scored 882.12 points out of 900 for the year 2013/14 and were hoping to achieve a higher score for 2014/15. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to ensure continuity of care.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the prescribing and dosage of long term medicines for example, aspirin and warfarin.

One GP in the practice undertook minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance for joint injections and small skin lesions.

We spoke with a GP about the care of patients with cancer. The GP told us that patients who were newly diagnosed were reviewed by GPs in the practice but there was no specific cancer review appointment offered by the practice. GPs we spoke with were aware of the two week wait target around suspected cancer referral.

Patients who had undergone tests and were waiting for the results would be requested to telephone the practice after 2pm to obtain the results of their tests. This gave the doctors time to assess the results that they had received during the morning. If the results were clearly outside of normal ranges, then reception staff would be asked to contact the patient to make an appointment or the GPs would call the patient themselves. It was the practice policy, in these cases, to give results to the patient in person or, if in the case of a child, to the parents only.

### Effective staffing

The practice had a recruitment policy for clinical staff. Staff were qualified for their roles. We saw examples of the staff induction training. There was a training matrix that stipulated how often mandatory training should be undertaken. Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support, safeguarding, fire and moving and handling.

The practice manager told us that the practice actively encouraged staff development for the benefit of the practice and patients. A member of reception staff told us that they had completed a national vocational qualification (NVQ) for health care assistants. We were told by some reception staff that they had recently been supported to undertake training for phlebotomy, for taking blood. We were told that if staff identified a course they would like to attend, they would be asked to explain why it would be useful to attend the course and what impact it would have on patient care and funding would be provided appropriately.

Yearly appraisals had taken place and staff we spoke with confirmed that they received these. There was evidence in staff files of the identification of learning needs and continuing professional development (CPD).

### Working with colleagues and other services

The practice proactively identified patients and their carers who may have needed on-going support. The practice provided visits for those who were housebound or too ill to visit the surgery.

Quarterly meetings with the palliative care team were held at the practice to review their palliative care patients. However, if there is a problem the practice would contact the palliative care team if they were concerned about any patient. The practice was signed up to the palliative care local enhanced service (LES) for this year. This LES is aimed at developing good practice and improving end of life care (EOL) care in response to local needs and priorities, sometimes adopting national service specifications.

The practice worked closely with the wider primary health care team but the district nurses were based elsewhere. The GPs told us that they would like to have the district nurses based at the practice. We were told that there was a new integrated primary care team starting from October 2014 and the practice hoped to work more closely with the wider team of district nurses, dementia nurse and palliative care teams.

Good

# Are services effective?

## (for example, treatment is effective)

The practice had joint multidisciplinary team meetings with the community matron and district nurses to look at their most vulnerable patients and it was planned to continue this year with the "Avoiding Unplanned Admissions" LES. This local enhanced service (LES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or readmission. The practice had a learning disability register which had recently been updated after liaising with the learning disability team. The practice had plans to initiate health checks for people with learning disabilities in this directed enhanced service (DES) later this year.

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. However, we were told that the practice had some difficulty with the hospital over referrals for vascular surgery, histology and pathology access.

### Information Sharing

The practice had an internal messaging system which allows staff to send messages regarding patients to clinical and non-clinical staff as required. These messages could then be transferred onto the patients' records if necessary. It was also used for general messages between colleagues which saved time and was more efficient, and provided an audit trail.

### Consent to care and treatment

The practice had a consent protocol that detailed the different types of consent and how to obtain consent including consent for children under the age of 16 who had sufficient understanding and intelligence to enable them to fully comprehend what was proposed (known as Gillick Competence) so that they would be able to give consent. We were told that for children under 16 (except for those who have Gillick Competence), someone with parental responsibility should give consent on the child's behalf. We spoke with one member of reception staff who told us that when children or adults with learning disabilities visited the practice, they would always have their carers with them.

### Health Promotion & Prevention

The practice had a range of patient information leaflets in the waiting area. We saw posters around the practice promoting flu jabs, "Stoptober" the initiative to help patients stop smoking in October and information around thyroid problems. A practice booklet was also available either in paper form or electronically from the practice's website. Information included details of cervical screening clinics, family planning clinics, child health and immunisation. The practice provided individual screening for chlamydia for patients aged 26 and above.

The practice provided diabetic, weight management, smoking cessation and asthma clinics that were run by the nurses and health care assistants in conjunction with the doctors. Patients were offered smoking cessation advice from the health care assistant. Smoking cessation medicines were prescribed and patients also had the option to access other smoking cessation services. We were shown records from the Kent Community Health NHS Trust "stop smoking" adviser service, that the practice had successfully helped 56 patients to stop smoking within a one year period.

The health care assistants undertook 24 hour blood pressure monitoring and electrocardiogram (ECG) tests that record the electrical activity of the heart. They told us that they also ran health check sessions to prevent heart disease, kidney disease and stroke, and invitations were sent out to patients to attend. The practice nurse was the diabetic lead nurse and undertook annual reviews of patients with diabetes. The practice nurse told us that she supported the QOF (Quality and Outcomes framework) for diabetes by undertaking audits.

The practice offered influenza and pneumonia vaccinations for patients over 65 years of age. Patients of 75 years or over, could have an annual check with the practice nurse.

The practice offered an immunisation programme for babies and pre-school age children. There was a dedicated GP responsible for overseeing the primary care needs of children at a home for learning disabilities. These children's physical health needs were regularly assessed and care was provided based on the results of those assessments.

Good

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

There were arrangements in place to ensure patients received care in an environment which promoted privacy and dignity. The practice had a policy for privacy and dignity. Consultation rooms were private and protected patients' privacy and dignity. Clinical staff told us that when an examination was in progress, they would close the blinds and pull curtains around the examination couch and if necessary, lock the door, in order to protect the patient's privacy.

Patients chose whether they wished to see a male or female doctor or nurse where available. The practice had a chaperone policy and we looked at records and saw that staff had received chaperone training. We spoke with staff about respecting patients' privacy and confidentiality. The practice manager told us that all reception staff in the practice had completed the on-line learning module for this topic. Staff were able to give particular examples of how they ensured patients' dignity was maintained. We spoke with the phlebotomist who told us that they did not leave their computer screen on when they were not in the room or if a member of staff entered the room.

During our inspection we spoke with eight patients. Patients were complimentary about the care they received and told us that the staff were helpful, knowledgeable and they felt safe and well cared for. We looked at 44 completed comment cards. The majority of comments we received were positive. Some patients said they had used the practice for a long period of time and they were satisfied with their care.

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

Nursing staff we spoke with told us that before any invasive procedure was undertaken, they would inform the patient and would gain consent. Nursing staff told us they would not perform any procedure that patients' who lacked capacity did not understand. They told us that if they were concerned that a patient did not have capacity to understand proposed care or treatment, they would discuss this concern with a GP. Nursing staff told us that in the case of a patient who lacked the capacity to consent, an advocate or carer would be encouraged to accompany them for their appointment. We looked at training records and saw that staff had received training in the Mental Capacity Act 2005 (MCA2005).

The practice had a learning disability register which had recently been updated after liaising with the learning disability team. These adult and children's physical health needs were regularly assessed and care was provided based on the results of those assessments. We spoke with one member of reception staff who told us that when children or adults with learning disabilities visited the practice, they would always have their carers with them.

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

Patients and those close to them were supported to receive emotional support from suitably trained staff if they needed it. Counsellors were available at the practice and patients were referred to them by the doctors. The practice also kept an up to date list of telephone numbers for counselling services and the crisis team. We saw that the practice had posters in the waiting area signposting patients for information on dementia and counselling.

We were told that the practice had links with the local hospice and patients for bereavement counselling were supported to self refer. We were told that the practice had links with counsellors and there was one who specialised in the care of children. We saw that the practice had received feedback from counsellors and looked at letters from various patients who were helped.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice had a Patient Participation Group (PPG) who they worked with to address concerns from patients. We looked at minutes of meetings held at the practice of the PPG and saw that car parking had been discussed. This was because there were three GP practices, local residents and Royal Mail staff who used the parking facilities and patients were finding it difficult to park. It was agreed that Royal Mail staff and local residents would be written to requesting them not to use the practice car park during surgery hours. It was also agreed that Orchard Practice PPG would work closely with one of the other practice's PPG with whom they shared the premises and car park. We did not manage to speak with any members of the PPG.

We saw from the last practice patient survey in February 2014, in which the practice had received 505 responses that most respondents were satisfied with the practice overall. There was significant satisfaction with the practice nurses with over 99% of patients feeling happy with the service they received. The majority of respondents (82%) felt that they were treated with courtesy and efficiency by the reception staff.

We saw that there was dissatisfaction at the time taken to get an appointment and that an increased number of patients experienced a longer waiting time either for a GP of choice or any GP. The practice had introduced an answerphone facility and encouraged those who could to use the internet for booking appointments. The availability of a particular GP was an issue that the practice reviewed regularly.

The practice had a monthly patient newsletter called Practice Eye which gave patients up to date information and a general overview of the practice. Via the practice website, patients could request a copy of the practice eye which was emailed to them.

### Tackling inequity and promoting equality

The practice told us it did not have specific groups of patients in vulnerable circumstances such as travellers, homeless people or asylum seekers. However, staff had access to interpreters via the internet and information in different languages. In addition, there was an agreed policy that the practice would use its own address for anyone that was homeless to ensure they were able to receive appropriate care and support. There was a loop for patients who had a hearing impairment and, if required, they would contact a local service for signing for patients who had a hearing impairment.

The practice had a learning disability register which had recently been updated after liaising with the learning disability team. Patients with learning disabilities (excluding children) were assessed and an annual review was undertaken of their physical, psychological and social circumstances. We saw that there was disabled access throughout the surgery, however, the counter at the reception was high.

### Access to the service

The practice proactively identified patients and their carers who might need support. The GPs visited those who were housebound or too ill to visit the surgery. There were district nurses and community nurses who worked closely with the practice and were available to give nursing care to patients in their homes. The practice GPs made regular visits to four local care homes.

During the flu vaccination period between September and January each year the practice were flexible and offered patients the opportunity to have their vaccination on a Saturday.

### Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their was a complaints policy and a designated person who handled all complaints in the practice.

We saw that if a patient needed help in pursuing their complaint there were contact details for the

Kent NHS complaints advocacy service and the Parliamentary and Health Service Ombudsman. There were leaflets and posters in the patients' waiting room to guide patients on how to make a complaint and information regarding complaints was on the practice's website.

We looked at a sample of complaints that had been logged and saw that majority of them had been about getting through on the telephone to get an appointment.

# 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

We spoke with the senior partner GP who told us that the practice worked towards a strategy, based on a 'team' approach in providing good quality care and treatment for patients. They said that the practice had evolved over the last two years and was now a training practice, supporting a number of GP registrars to become qualified GPs. The senior partner told us they were a GP trainer and felt this helped to keep the practice up-to-date with relevant national guidance and best practice initiatives. The practice did not have a written vision statement or a business plan to inform individual or team objectives.

### Governance Arrangements

The governance lead for the practice was a named GP. We saw that there were processes in place and regular meetings were held to discuss governance issues. The practice operated a clinical audit system and addressed any areas which required improvement. The practice reviewed significant events and improvements were made when required. There were also mechanisms in place for improving practice and the environment based on risk assessments. Relevant fire safety checks were completed and electrical testing was up to date.

### Leadership, openness and transparency

There were regular team meetings to ensure that information was cascaded to all staff members. This included learning from incidents and any changes to practice across the organisation.

We spoke with a variety of staff working at the practice and we were told they felt there was an open culture and senior managers were supportive. Staff told us they felt part of a team and that they were provided with suitable opportunities for training and progression. Staff told us there was always someone senior available or who was contactable by phone if they needed advice.

### Practice seeks and acts on feedback from users, public and staff

The practice had a Patient Participation Group (PPG) who they worked with to address concerns from patients. We saw from the last practice patient survey in February 2014, that most respondents were satisfied with the practice overall. There was significant satisfaction with the practice nurses with over 99% of patients feeling happy with the service they received. The majority of respondents (82%) felt that they were treated with courtesy and efficiency by the reception staff.

### Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. The practice was a training practice and currently had two registrars. All the GPs and nurses were involved in the training of future GPs. The practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (formerly called the Deanery). Trainee GPs were encouraged to provide feedback on the quality of their placement to Health Education Kent, Surrey and Sussex and this in turn was passed to the GP practice.

The practice had completed reviews of complaints, significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example we saw from the minutes of a clinical governance meeting that an incident was discussed regarding a review of patients' medicinces at a residential care home where the GP found that the home had doubled up on one patient's medicines for two weeks. The home responded and the dose was reduced down with immediate effect.