# The Manor Clinic

## Quality Report

The Surgery
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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 Manor Clinic on 11 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, responsive, caring, effective and well-led services. It was also good for providing services for the care to older people, people with long term conditions, families, children and young people and working age people (including those recently retired and students). It was outstanding for providing services for the care of people whose circumstances may make them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, working in partnership with seven other GP practices and a local crisis centre for homeless people.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

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was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw one area of outstanding practice:

- The practice had worked with the local crisis drop-in team to support those people in the local community who were homeless or asylum seekers in vulnerable circumstances. The practice had registered these people as patients at the practice.

**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 and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice learnt from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the findings from a health and safety review undertaken in November 2014. There were enough staff to keep patients safe. Significant events were discussed at meetings with another GP practice in the area and also through the Invicta challenge fund's Leading Improvements in Safety and Quality (LISQ) meetings, held with seven other practices as a learning event. The practice had completed reviews of significant events and other incidents and shared these with staff via their regular monthly meetings to ensure the practice improved the outcomes for patients. For example, we saw that in March three significant events had been discussed. One of these was a needle stick injury to a member of staff from a clinical waste bag. We saw that following discussion, the incident was then given the GP involved, to reflect and respond to the event, and would be discussed at the next meeting regarding the learning outcomes.

### Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. 1,611 patients received the flu vaccine this year out of 2,402 who were eligible equalling 67%. Last year's performance for all immunisations for children was about average for the CCG. Staff referred to guidance from NICE and used it routinely. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, we saw that NICE guidelines had been discussed for prescribing in diabetes. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice had well established links with the local area commissioners. Meetings took

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place on a regular basis to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future. For example, enhanced community care with short-term residential facilities in the community to avoid hospital admissions and for patients with urgent mental health needs, a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home or at their GP.

Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams. The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. For example, when comparing the overall patients' experience the practice had achieved 100% compared to the CCG average of 96.77%. We observed a patient-centred culture. Staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. During our inspection we saw paramedics arrive with a patient who was unwell and did not want to go into hospital, this was causing anxiety to the patient. When the patient arrived at the practice they were immediately seen by the GP who gave antibiotics and steroids, and assessed that the patient did not need to attend A&E but could be treated at home. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. The practice worked closely with the Clinical Commissioning Group (CCG). We noted one GP always attended the CCG full council meetings held quarterly and one of the GP partners sat on the Invicta's health board to discuss issues affecting practices across the locality such as increased patient population due to asylum seekers and homeless people.

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

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical

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Commissioning Group (CCG) to secure service improvements where these had been identified. The practice is one of eight practices in the South Kent Coast Clinical Commissioning Group (CCG) (one of 20 CCGs selected nationally) to be awarded the Prime Minister's Challenge Fund to enable them to establish a GP service based at the local NHS hospital, allowing all the eight local practices in the Folkestone area to host primary care services, seven days a week, from 8am to 8pm and an urgent home visit service outside of core practice hours (8am-6.30pm). Appointments are booked via the practice's reception or NHS 111.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an urgent clinic held every afternoon with booked on the day appointments. Urgent appointments could be given in the morning at the end of the GP clinics or GPs could provide an advice call. Children could be seen urgently depending on the degree of urgency. There were three embargoed appointments dedicated especially for children at the beginning of the urgent appointments clinic. There were nurse clinical practitioner appointments Monday to Wednesday from 8.30am until 5.45pm for minor problems such as coughs, colds and chest infections.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. We saw from minutes that team meetings were held regularly, at least bi-monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held. Staff told us about the social meetings the practice had. For example, summer outing for staff, partners and children and ad-hoc evening meals out two or three times a year.

# 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. Examples of good were that the practice provides GP support for patients in a 10 bedded unit at the local Social Services Centre for patients whose vulnerability meant they needed additional support following discharge from hospital. The aim of this was to reduce hospital re-admission rates and facilitating early discharge from hospital. GPs from the practice carried out weekly ward rounds in four of the care homes where they provided care to older people. This enabled them to identify risks to older patients who had deterioration in their health for example, with regular meetings with the care home managers to discuss patients' health, care plans, medication, investigations and disease monitoring.

### People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 314 (68.11%) of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations. For example, the healthcare assistant (HCA) followed the electronic health check protocol in referring patients who had risk factors identified, they would be booked within days for further investigations such as oral glucose tolerance test, 24hr blood pressure monitoring, cardiac event monitoring, fasting glucose, cholesterol and bloods which would be done at the practice.

The practice worked closely with community nursing teams and the integrated care team to support patients with long-term conditions and those with complex needs who received care and treatment from a range of services. The practice had dedicated clinics run by trained and experienced staff for asthma, diabetes and chronic obstructive pulmonary disease (COPD).

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**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.

When looking at immunisation rates, overall the practice were average for all standard childhood immunisations when compared to national average and the area clinical commissioning group (CCG). For example, for infant meningococcal C vaccine known as Men C, the practice had achieved 98.6% compared to the CCG rate of 97.7%. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw that there were "priority seats" in the waiting room for families, pregnant women and patients with mobility problems and a secure pram park at the side of the practice.

**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. 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 reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice worked closely with the local treatment centre, a charity for homeless people, in contacting patients and arranging referrals and follow up health assessments. People in vulnerable circumstances were able to register with the practice including asylum seekers. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and over 70 out of 81 of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in

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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. The practice kept a register of patients experiencing poor mental health. Records showed there were 116 patients experiencing poor mental health including 39 patients with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It 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. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

# Summary of findings

## What people who use the service say

All of the six patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the nine patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that comments were positive. Patients told us the staff were always helpful, professional, caring and treated them with dignity and respect. They said the nurses and doctors listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy. Some patients told us they experienced problems getting through to the practice on the telephone to make an appointment. Most patients however told us the appointment system was easy to use and met their needs.

The results from the National Patient Survey showed that 74% of patients said that their overall experience of the practice was good or very good and that 67% of patients would recommend the practice to someone new to the area.

The practice sought feedback from staff and patients, which it acted on. The practice had a patient participation group (PPG) who they worked with to address concerns from patients. The last practice patient survey in March 2014 demonstrated that most respondents were satisfied with the practice overall.

## Outstanding practice

- The practice had worked with the local crisis drop-in team to support those people in the local community who were homeless or asylum seekers in vulnerable circumstances. The practice had registered these people as patients at the practice.

# The Manor Clinic

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

## Background to The Manor Clinic

The Manor Clinic is situated in a converted house and located in Folkestone town centre. The building has benefitted from subsequent extensions and refurbishments improving space, access, infection control and facilities. Wheelchair access to the building is through the front door. The practice has one of the most deprived and vulnerable populations in the UK.

A team of four GP partners, one locum GP, a nurse practitioner, a practice nurse, one health care assistant, a practice manager, receptionists, medical secretaries and administrative staff provide care and treatment for approximately 7,300 patients. There are four male and two female doctors at the practice to provide patients with a choice of who to see. The practice had recently recruited two new female GPs.

Practice nurses are qualified and registered nurses. The nursing team provide a wide range of care in the treatment room, including immunisations, blood pressure monitoring, dressing of wounds, cervical smears, electrocardiogram (ECG records electrical activity in the heart) and chronic disease checks such as diabetes and asthma. The practice nurse is able to give travel advice as well as any vaccinations needed including Yellow Fever.

The healthcare assistant supports the practice nurses with their daily work and carries out tasks such as phlebotomy (drawing blood), blood pressure measurement and new patient checks. They may act as a chaperone when a patient or doctor requests one.

Appointments were available from 8.15am until 6.30pm on weekdays and 8.30am to 12.30pm every third Saturday (and any Saturday when demand was high). There was an urgent clinic held every afternoon with booked on the day appointments. Urgent appointments could be given in the morning at the end of the GP clinics or GPs could provide an advice call. Children could be seen urgently depending on the degree of urgency. There were three embargoed appointments dedicated especially for children at the beginning of the urgent appointments clinic. There were nurse clinical practitioner appointments Monday to Wednesday from 8.30am until 5.45pm for minor problems such as coughs, colds and chest infections.

The practice provides an out-of-hours service to their own patients and appointments were booked via the practice's reception or NHS 111 when the practice is closed.

## Why we carried out this inspection

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

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

# Detailed findings

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

## 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 February 2015. During our visit we spoke with four GPs, the practice manager, one practice nurse, one health care assistant, five receptionists, one senior receptionist, one medical secretary and six patients who used the service. We reviewed nine comment cards the practice's Family and Friends Test and NHS Choices website where patients and members of the public shared their views and experiences of the service.

Good

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. For example, records showed that a fire risk assessment had been carried out in July 2014 and the actions to be taken were fire training, a log book and the front door to be marked as a fire exit. Evidence showed that all of these actions had been completed in July 2014. In November 2014 the practice manager carried out a health and safety review with action points listed. The action plan included that all staff to be made aware of locking the clinical a waste bin. During the inspection we found that the clinical waste bin was locked.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held bi-monthly, or weekly if an urgent discussion needed to take place, to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, minutes of the GPs meeting showed that there has been a discussion where there had been an alleged assault a member of staff. The decision was made that the patient would only be seen with the presence of a chaperone.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. As well as discussing significant events with staff, they were discussed with people outside the practice so that improvement could be shared. We saw that significant events were discussed at meetings with another GP practice in the area and also through the Invicta challenge fund's Leading Improvements in Safety and Quality (LISQ) meetings, held with seven other practices as a learning event.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. For example, we saw that where one patient had been given the wrong medicine, the senior GP called the patient to discuss the incident and a verbal apology given. An alternative method for the patient to receive the correct medicine in the form of an injection was agreed so that the risk of this occurring again was omitted.

National patient safety alerts were disseminated by the practice manager to GPs and nurses. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, we were told about an alert for the use of Heparin (a medicine used to treat and prevent blood clots in the veins, arteries, or lung). They also told us alerts were emailed and discussion took place at the practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Minutes of practice meetings showed that national patient safety alerts were discussed with action points.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example, all clinical staff had level three training for children and level two training for adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One GP told us about concerns they had for a child. They told us that they consulted with another GP to examine the child and concluded that this was not a safeguarding issue. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours

and out of normal hours. Child safeguarding posters were displayed throughout the practice and contact details were easily accessible to staff on the shared electronic system EMIS.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. We were told about one GP who was considering making a referral to the safeguarding adult team for one patient, who was currently living in a care home. The GP spoke at length to the patient, who he believed had capacity, and the manager at the home. The GP also arranged a meeting with the patient's wife when she visited. We were told that at the GP was not concerned after speaking to the patient and the home manager, and deferred making the adult referral.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken a criminal records check through the Disclosure and Barring Service (DBS), chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, a review for the use of antibiotics for various illness. Of the 11 patients reviewed, there was inappropriate prescribing for four patients. Changes proposed were to review antibiotics used the next year and also follow antimicrobial guidance by the CCG.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. When looking at immunisation rates, overall the practice were average 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 94.6% compared to the CCG rate of 96.5%. The nurse practitioner was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed. We saw that the practice had supported a community matron in their training as an independent prescriber and had received regular supervision and support from a GP.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example, medicine management meetings were held with the GP lead to discuss emergency contraception. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had a prescription security protocol which outlined the security measures for prescriptions, both during practice opening hours, and throughout evenings and weekends. 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 request them either in writing, on line or put the repeat prescription paper request in the post box in reception. Repeat prescriptions could also be sent electronically to a nominated chemist of the patient's choice. The practice did not routinely take prescription requests over the telephone.

### Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning

records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out a management of waste audit in September 2014 and handling of specimens and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, clinical staff told us that they used the sanitizing hand gel after every patient. We saw that on 31 December 2014 disposable curtains had been changed in the clinical rooms and staff told us that pillows and the disposable couch roll were changed between each patient. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records dated 6 February 2015 that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of 3 February 2015. A schedule of testing was in place. We saw evidence of calibration of over 60 pieces of equipment; for example dopplers (an ultrasound test used to reflect sound waves to see how blood flows through a blood vessel), spirometers (used for lung function tests), blood pressure measuring devices and the fridge thermometer.

### Staffing and recruitment

Records we looked at 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 and non-clinical staff. The practice had recently recruited two new female GPs.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks in 2013 of the building following remodelling, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw that a fire risk assessment has been carried out 23 July 2014. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team

meetings. For example, the practice manager had shared the findings from a health and safety review undertaken in November 2014. The action plan showed what was recommended such as all sockets and plugs being checked and a high priority for caution signs to be put above sockets. Warning signs were displayed above sockets throughout the practice

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylactic shock and low blood sugar. Processes were also in place to check emergency medicines were within their expiry date and suitable for use and we saw that they were.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of domestic services, flood, staff shortages and IT failure. The document also contained relevant contact details for staff to refer to. For example, contact details of the suppliers for water and electricity and who to contact in the event of failure.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken. The practice had a health and safety policy that included fire prevention and safety and this was covered during new staff inductions. Staff we spoke with clearly described their roles and responsibilities in keeping patients safe in the event of a fire.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, we saw that NICE guidelines had been discussed for prescribing in diabetes. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as dermatology, gynaecology, occupational health and wellbeing, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported cross referral by reducing referrals to hospitals and providing local expertise.

The senior GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with chest or urinary tract infections which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to follow up patients who had attended accident and emergency (A&E) or had been an unplanned admission to hospital. We saw an example of an entry on the computer system stating "open access" for these patients. The practice would follow up the patient by writing and also calling them to encourage them to visit the practice.

The practice held quarterly multi-disciplinary meetings between the practice, community nurses and palliative care nurses. This enabled the practice to respond quickly to the needs of palliative care patients. We saw there was a system in place that identified patients at the end of their life. This included a palliative care register of nine patients and alerts within the clinical computer system making clinical staff aware of their additional needs. The practice had a dementia register to ensure that they had recorded all 39 patients with dementia.

All GPs we spoke with used national standards for the referral of patients, for example patients with suspected cancers to ensure they were seen within two weeks. We saw that two week referrals were discussed at the weekly GP meeting and decided that the GPs would code the Rapid Access referral form, and after it had been faxed, photocopied and the original sent, the copied form would be kept, and checked on a weekly basis, to ensure the patient had been given an appointment. The practice used the Referral Assessment Service (RAS) to refer patients to other services through choose and book (a system that enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) and we saw an example when this had been carried out. We saw that regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

One GP in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The GP was appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used that in their learning. For example, we saw that an audit of clinical diagnosis and histological

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# Are services effective?

## (for example, treatment is effective)

diagnosis of minor surgery had been carried out to make sure that the GP was excising benign skin lesions and also improving their clinical diagnosis. The outcome of the audit was that the GP's standard for accuracy of clinical diagnosis was 70% of the histological diagnosis and that all skin lesions cut were 100% benign.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of Metformin (used to treat patients with type 2 diabetes). Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients and had achieved a score of 883.78 out of 900 (98.2%). For example, 83.5% of patients with asthma had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) dementia, depression, hypertension, rheumatoid arthritis. 100 per cent of all patients on the dementia register received an annual review which included a medication review. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, child immunisation, antibiotic prescribing and hospital referral rates.

### Effective staffing

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 annual basic life support. We noted a good skill mix among the doctors with one having additional diplomas in sexual and reproductive medicine, and one with diplomas in children's health and obstetrics, dermatology and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example we saw that five out of nine receptionists had been supported to undertake National Vocational Qualifications (NVQ) in customer service.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, leg ulcers and anticoagulation (an anticoagulant is a medicine that stops blood from clotting). Those with extended roles seeing patients with

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# Are services effective?

(for example, treatment is effective)

long-term conditions such as asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. 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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made seven referrals in the last six months through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). We were told that GPs did not tend to use Choose and Book regularly, although patients were offered it, and that most of the referrals were still sent by post, fax or email.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients were able to access information about Summary Care Records in the practice leaflet.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient

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# Are services effective?

## (for example, treatment is effective)

did not have capacity to make a decision. We saw minutes of best interest meetings held at a local care home for people with a learning or physical disability where the practice looked after eight residents. The senior partner meets with the manager on a regular basis to review these patients. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

### Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity. For example, the increased level of homeless people in the area and women's refuge.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 314 (68.11%) of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations. For example, the HCA followed the electronic health check protocol in referring patients who had risk factors identified, they would be booked within days for further investigations such as oral glucose tolerance test, 24hr blood pressure monitoring, cardiac event monitoring, fasting glucose, cholesterol and bloods which would be done at the practice.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and over 70 out of 81 had received an annual physical health check. The practice did not offer a smoking cessation service but advised patients to speak to a local chemist or the NHS Stop smoking service. Information, guidance and contact details were available for patients in the practice leaflet and on their website. The patient was asked by either a clinician, or administrative member of staff if they smoked, the information was entered into the patient's records. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84.9%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national bowel cancer screening showed that 11.8% of patients who were eligible had undertaken screening. For breast cancer screening, 36.5% of patients who were eligible over the last three years had had a mammogram.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. 1,611 patients received the flu vaccine this year out of 2,402 who were eligible equalling 67%. Last year's performance for all immunisations for children was about average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. When looking at immunisation rates for infant meningococcal C vaccine known as Men C, the practice had achieved 98.6% compared to the CCG rate of 97.7%.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from a survey of patients undertaken March 2014 by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good (89% compared to the local CCG of 86%). The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 85% saying the GP gave them enough time. When comparing the overall patients' experience the practice had achieved 100% compared to the CCG average of 96.77%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and they were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice had a telephone hub which was located on the first floor away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 70% of practice respondents said the GP involved them in care decisions and 74% felt the GP was good at explaining treatment and results. Both these results were about average compared to the local CCG area. The results from the practice's own satisfaction survey showed that 94% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

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

Patient information leaflets were available in paper and electronic form that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, counselling services and a bereavement support group. Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient

Good

# Are services caring?

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. The practice's computer system alerted GPs of a bereavement and the family were given open access. Anyone needing confidential emotional support could call the Mental Health Matters helpline and contact details were available in the practice leaflet or on line.

Staff were supportive in their manner and approach towards patients. Patients told us they were given the time they needed to discuss their treatment as well as the options available to them and they felt listened to by the GPs and other staff within the practice.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had well established links with the local area commissioners. Meetings took place on a regular basis to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future. For example, enhanced community care with short-term residential facilities in the community to avoid hospital admissions and for patients with urgent mental health needs, a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home or at their GP.

The practice worked closely with community nursing teams and the integrated care team to support patients with long-term conditions and those with complex needs who received care and treatment from a range of services. Patients told us they were referred promptly to other services for treatment and test results were available quickly. Staff told us that the needs of different patients were always considered in planning how services would be provided. For example, arranging home visits for housebound patients.

The practice had a patient participation group (PPG). Terms of reference and the purpose of the group had been established and implemented. A survey had been developed to distribute to patients and there was analysis of the results of previous surveys which were completed by patients. PPG representatives told us they had looked at ways of recruiting new members from all of the patient populations groups and these had been successful. The practice had a website containing a section dedicated to the PPG, where recent surveys and the group's annual report could be accessed by patients and members of the public. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, patients had commented that they had difficulty in getting through to the practice on the telephone. The practice had joined up with Kent and Medway Commissioning support led telephone project in a system that used to be used by the fire service, police and county councils. This was to ensure that if reception staff were unable to answer a call, as they were already taking a call, the call would be diverted to another telephone for it to be answered by another member of staff. If all staff were busy answering calls, there was a call waiting facility.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. People in vulnerable circumstances were able to register with the practice, including asylum seekers and those with "no fixed abode." We saw a recent example of how a member of the practice team had enabled a homeless person to register with the practice and helped them access benefits advice. The practice took the care of vulnerable people seriously. Homeless patients had access to that GP without an appointment. All patients could access the practice for appointments if they preferred.

The practice provided GP support for patients in a 10 bedded unit at the local Social Services Centre for patients whose vulnerability meant they needed additional support following discharge from hospital. The aim of this was to reduce hospital re-admission rates and facilitating early discharge from hospital.

The practice had access to online and telephone translation services and GPs who spoke a second language. There was access to a hearing loop for people who had hearing impairment.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. We saw that there were "priority seats" in the waiting room for families, pregnant women and patients with mobility problems. There was a secure pram park to the side of the practice.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice actively supported patients who had been on long-term sick leave to return to work by offering occupational health and wellbeing services to support fitness to work. The practice also offered occupational health services to the local ferry companies' employees.

### Access to the service

The practice is one of eight practices in the South Kent Coast Clinical Commissioning Group (CCG) to be awarded the Prime Minister's Challenge Fund to enable them to establish a GP service based at the local NHS hospital, allowing all the eight local practices in the Folkestone area to host primary care services, seven days a week, from 8am to 8pm and an urgent home visit service outside of core practice hours (8am-6.30pm). Appointments are booked via the practice's reception or NHS 111.

Patients were able to book an appointment by telephone, online or in person. Appointments were available from 8.15am until 6.30pm on weekdays and 8.30am to 12.30pm every third Saturday (and any Saturday when demand was high). There was an urgent clinic held every afternoon with booked on the day appointments. Urgent appointments could be given in the morning at the end of the GP clinics or GPs could provide an advice call. Children could be seen urgently depending on the degree of urgency. There were three embargoed appointments dedicated especially for children at the beginning of the urgent appointments clinic. There were nurse clinical practitioner appointments Monday to Wednesday from 8.30am until 5.45pm for minor problems such as coughs, colds and chest infections.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. The practice offered open access to the services it provided. During our inspection we saw paramedics arrive with a patient who was unwell and did not want to go into hospital, and this was causing anxiety to the patient. When the patient arrived at the practice they were seen by the GP who gave antibiotics and steroids, and assessed that the patient did not need to attend A&E but could be treated at home.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and 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. The practice leaflet and website explained that there was a complaints procedure and the complaints pack explained the procedure, to make sure that concerns were dealt with promptly. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at seven complaints received in the last 12 months and found they had all been reviewed and analysed in a timely way and that there was openness and transparency in dealing with the compliant.

For example, we saw that a patient had complained regarding a prescription requested by a consultant and the quantities of medication issued. We saw that the complaint had been analysed and the practice manager ensured quantities could be changed and that the prescription would be issued as requested.

We saw that an annual meeting with the whole practice team would include "Learning from Complaints", whereby the complaints received during the year would be discussed with all the practice team. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

# 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. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice vision and values included providing accessible, holistic and evidence based medicine in a caring and friendly environment for the betterment of all their patients. The practice had adopted 11 key values including care beyond the expected and patients involved in decision making to underpin their mission statement. We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All eight policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at bi-monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice held management meetings and bi-monthly primary health care, significant event and safeguarding meetings attended by clinical staff and managers. These incorporated multi–disciplinary meetings with external health and social care professionals where required for example safeguarding and cancer/palliative care reviews.

All staff attended the significant review meetings as a means of communicating and sharing learning. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice worked closely with the Clinical Commissioning Group (CCG). We noted one GP always attended the CCG full council meetings held quarterly and one of the GP partners sat on the Invicta's health board to discuss issues affecting practices across the locality such as increased patient population due to asylum seekers and homeless people.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw audits to monitor patient experience and quality and to ensure treatment was being delivered in line with best practice. We were provided with a range of completed audits. These included clinical and non-clinical audits such as a phone call audit to inform the practice appointment system. Clinical audits included identifying patients at risk of diabetes and minor surgery for lesions (any abnormal change involving any tissue). We saw from all audits outcomes and actions were recorded and any changes which resulted from the audits were shared with staff during team meetings.

A peer review system took place with neighbouring GP practices to learn from significant events. From the summary of significant events we were provided with and from speaking with staff we saw learning had taken place and improvements were made.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These guaranteed equipment was safe to use and maintained in line with manufacture guidelines.

The practice held bi-monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

### Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least bi-monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team

# Are services well-led?

Good

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

meetings. We also noted that team away days were held. Staff told us about the social meetings the practice had. For example, summer outing for staff, partners and children and ad-hoc evening meals out two or three times a year.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, a recruitment policy and a training policy which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment at work. Staff we spoke with knew where to find these policies if required.

All staff had an appraisal meeting, giving staff the opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. All staff we spoke with confirmed they had had an appraisal. GPs also received appraisal through the revalidation process. Revalidation is where licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise.

### Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through the national patient survey, the NHS friends and family test, PPG surveys, suggestion box, compliments and complaints. We saw that there was a detailed complaints procedure in place, available for patients in the practice leaflet and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

We reviewed the results of the national patient survey carried out in 2013/14 and noted 100% describe their overall experience of the practice as good. In December 2014 the practice began to ask patients to participate in the friends and family test (The NHS friends and family test (FFT) was an opportunity for patients to provide feedback on the services). The practice had a Patient Participation Group (PPG) which was made up of a diverse range of patients. The PPG meet on a regular basis to review the findings from surveys and to discuss ways in which patient experience could be improved.

The practice made available to patients a newsletter, providing patients with updates such as changes to appointments, repeat prescriptions and how to contact carers' support. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

### Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

Peer support and team work were evident throughout the practice and staff had access to regular formal appraisals and supervision. From staff records and speaking with staff they told us they regularly attended training courses. Mandatory training was arranged for staff and they were able to request relevant training courses that would enhance their performance at work.

Clinical staff told us they were supported to maintain their continual professional development (CPD). Staff told us they felt very well supported at work and that the practice had an open door policy so they could raise any concerns.

The practice was not a GP training practice, however, the practice supported 5th year medical students from Kings College London who were training to be qualified as a doctor and had access to a senior GP throughout their placement for support. We saw positive feedback from the trainees through evaluation forms.

The practice had completed reviews of significant events and other incidents and shared these with staff via their regular monthly meetings to ensure the practice improved the outcomes for patients. For example, we saw that in March three significant events had been discussed. One of these was a needle stick injury to a member of staff from a clinical waste bag. We saw that following discussion, the incident was then given the GP involved, to reflect and respond to the event, and would be discussed at the next meeting regarding the learning outcomes and written up in detail.