

Church Lane Surgery

Quality Report

Church Lane
New Romney
Kent

TN28 8ER

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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

Requires improvement



Are services safe?

Good



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive to people's needs?

Requires improvement



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 Church Lane Surgery (also known as Church Lane Health Centre) on 3 October 2017. Overall the practice is rated as requires improvement.

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

- We found there was a system for reporting, recording, investigating and learning from significant events.
- The practice had defined systems, processes and practices to minimise risks to patient safety including, infection prevention control audits and health and safety assessments.
- We found medicines were prescribed and monitored appropriately.
- The practice were reviewing their disease registers to ensure they were reflective of their patients clinical needs.
- The practice were currently reviewing the needs of their patient population and were diversifying their clinical team to improve their responsiveness.
- The practice had reviewed the findings of the national GP patient survey and had an action plan to address the concerns and to improve the care provided to patients and their families.
- All patients we spoke with told us they found it difficult to make an appointment, online, in person or on phone. They were concerned there was little continuity of care with the practice employing sessional GPs and recent changes to the practice nursing team.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- There was a clear leadership structure and staff welcomed greater stability to the team with the recent appointment of the interim practice manager.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

Summary of findings

- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The practice sought feedback from staff and patients. The patient participation group and practice agreed their relationship had improved over the past three months.

The areas where the provider must make improvement are:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences

The areas where the provider should make improvement are:

- Strengthen systems to identify where safety alerts had not been consistently actioned, follow up on children who fail to attend appointments with the practice and secondary care and patients who failed to attend national screening programmes.
- Improve the identification and services provided to carers.
- Ensure staff are confident in using the hearing loop.
- Embed changes to disease registers to accurately reflect patients needs.
- Ensure consistent coding of the resuscitation status of patients within their care plans.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- We found there was a system for reporting, recording investigating and learning from significant events.
- The practice had defined systems, processes and practices to minimise risks to patient safety including, infection prevention control audits and health and safety assessments.
- We found medicines were prescribed and monitored appropriately.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had arrangements to respond to emergencies and major incidents.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Staff were aware of current evidence based guidance.
- Disease registers were being reviewed to accurately reflect patient needs and inform care and treatment.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- Staff had received appraisals and personal development plans were in place for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey, published in July 2017 showed patients rated the practice below the local and national averages for aspects of care provided by GPs.
- Patients survey information we reviewed showed that some patients said they were treated with compassion, dignity and respect whilst other patients reported insufficient consultation time.
- Information for patients about the services available was accessible.

Requires improvement



Summary of findings

- The practice identified carers and some staff had been training to signpost patients to relevant services.

Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services.

- The practice had a weighed patient population in recognition of their aging demographic and the complex needs of many of their patients. However, the practice believed this was not reflective of the extent of the clinical needs of the community.
- The practice was reviewing practices and diversifying their clinical team to improve their responsiveness.
- The practice told us 5% of patients failed to attend their appointments weekly.
- All patients we spoke with said they found it difficult to make an appointment, online, in person or on phone. They were concerned there was little continuity of care with the practice employing locum GPs.
- Information about how to complain was available and evidence from complaints reviewed showed the practice responded appropriately to concerns. Learning from complaints was shared with staff to improve services.

Requires improvement



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff welcomed greater stability to the team with the appointment of the interim practice manager.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. However, despite this being established improvements were required ensure they captured all risks.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The practice were not meeting patient demand and were reviewing appointment availability and the diversification of the clinical team to improve the responsiveness of the service.
- The practice sought feedback from staff and patients and the patient participation group and practice agreed their relationship had improved over the past three months.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older people. The provider is rated as good for safe, effective and well led and requires improvement for caring and responsive. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice had a diverse clinical team consisting of GPs, practice matron, practice nurses, assistant practitioner, healthcare assistant, clinical pharmacist and the paramedic practitioner to respond to the needs of the older patients in its population.
- The practice offered home visits and urgent appointments were available on the day.
- The practice matron was the clinical lead and point of contact for patients in supported living, residential and nursing accommodation.
- The needs of palliative care patients were reviewed during clinical meetings.
- Patient care plans were prepared in partnership with relevant health and social care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of people with long-term conditions. The provider is rated as good for safe, effective and well led and requires improvement for caring and responsive. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Nursing staff had lead roles in long-term disease management. However, some services were being temporarily provided off site at a neighbouring practice pending the appointment of a nurse practitioner.
- The practice were revising their disease registers to ensure they were reflective of the patients clinical needs and appropriate reviews were being conducted.

Requires improvement



Summary of findings

- The practice prepared and reviewed care plans during clinical meetings in partnership with their health and social care partners.
- The practice had a diverse clinical team to respond to patients including GPs, nurse practitioners, practice nurses, paramedic practitioners, clinical pharmacists and a practice matron.
- The needs of palliative care patients were reviewed during clinical meetings.

Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. The provider is rated as good for safe, effective and well led and requires improvement for caring and responsive. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Children living in disadvantaged circumstances and/or who were at risk were flagged on the patient record system. However, the practice did not maintain a register of vulnerable children.
- The practice did not have an established system in place to ensure they followed up on children who failed to attend appointments with the practice and secondary care.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that they were not always able to get an on the day appointment for their child. The practice told us their policy was to see all children under 12 years of age with acute illness that day.
- The practice employed a regular female locum GP. However, some patients told us they could not always see a female GP.
- The practice worked with midwives and health visitors.

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider is rated as good for safe, effective and well led and requires improvement for caring and responsive. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The practice were reviewing their disease registers to ensure they were reflective of the clinical needs of their patients.
- The practice provided travel vaccinations.

Requires improvement



Summary of findings

- The practice held Meningitis ACWY vaccine clinics during the summer for students.
- The practice offered health promotion and screening services.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider is rated as good for safe, effective and well led and requires improvement for caring and responsive. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The care needs of patients receiving end of life care was reviewed during clinical meetings in partnership with health and social care professionals.
- Longer appointments were available on request.
- Some staff had received training of supporting patients access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider is rated as good for safe, effective and well led and requires improvement for caring and responsive. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The practice considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Requires improvement



Summary of findings

- The practice matron was the clinical lead for patients in supported living, residential and nursing accommodation and worked in partnership with the clinical pharmacist.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2017. The results showed the practice was performing below local and national averages. Two hundred and nineteen survey forms were distributed and 119 were returned. This represented 2% of the practice's patient list.

- 46% of respondents described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 84% and the national average of 85%.
- 32% of respondents described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.

- 28% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards, reviewed 32 share your experience forms submitted to the Commission directly and spoke to 12 patients including three members of the patient participation group. All patients reported difficulties accessing care and treatment.

Areas for improvement

Action the service **MUST** take to improve

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences

Action the service **SHOULD** take to improve

- Strengthen systems to identify where safety alerts had not been consistently actioned, follow up on children who fail to attend appointments with the practice and secondary care and patients who failed to attend national screening programmes.

- Improve the identification and services provided to carers.
- Ensure staff are confident in using the hearing loop.
- Embed changes to disease registers to accurately reflect patients needs.
- Ensure consistent coding of the resuscitation status of patients within their care plans.

Church Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Church Lane Surgery

Church Lane Surgery is also known as Church Lane Health Centre. It is part of Invicta Health Community Interest Company (CIC) who took on the APMS contract in September 2016. The practice is located in the south of Kent and provides services to rural communities.

All clinical rooms are situated on the ground floor and there is ramp access and assisted entry doors into the premises. There is car parking at the front of the premises and unrestricted parking on the public roads.

Church Lane Surgery provide services to 6,794 patients with a weighted population of 8,174 patients. The practice has an aging population, with above the national average numbers of male and female patients 45 years to 89 years of age. The practice has higher than the local and national prevalence for some chronic diseases such as chronic kidney disease, hypertension, heart failure, rheumatoid arthritis, diabetes, cancer and epilepsy. The service also have a high number of patients cared for within assisted living accommodation, nursing or residential homes. One percent of their patient list have learning disabilities. As a popular rural and coastal location the practice experiences seasonal increases in their patient list.

The practice employs locum GPs (male and female). The practice employs three GPs a day, two GPs provide clinical sessions and the third GP is responsible for conducting wider clinical duties. The practice share clinicians across both their practices. There are two practice nurses (female) who cover full clinics five days a week, a health care assistant (female) who conducts phlebotomy four mornings a week, a nurse practitioner who works two days a week and an assistant practitioner who works four days. All members of the nursing team are salaried employees.

The practice matron (female) is employed directly by the provider and works two days a week (Monday and Tuesday) as is the paramedic practitioner (male) who works full time but shares duties across two Invicta Health CIC practices. There are two clinical pharmacists (one full time male pharmacist and a part time female pharmacist) employed by the practice. One of the clinical pharmacists works full time and the other clinical pharmacist works two days a week. The practice has two female community health visitors aligned to the practice. The clinical and administrative team (receptionists, medical secretaries, administrators) are overseen by an interim practice manager and the Invicta management team.

There are arrangements with other providers such as Primecare to deliver services to patients outside of the practices working hours.

The practice address is; Church Lane Surgery, Church Lane, New Romney, Kent, TN28 8ER.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was

Detailed findings

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the district nursing team, Healthwatch and the NHS South Kent Coast clinical commissioning group. We carried out an announced visit on 3 October 2017. During our visit we:

- Spoke with a range of staff (the interim practice manager, GPs, members of the practice nursing team and reception staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events. Staff reported concerns to the practice manager and there was a recording form available. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

The practice had recorded 22 significant events in the last year, 12 were clinical incidents. We reviewed three incidents: one relating to the maintenance of equipment, one to the prescribing of medication and one to referrals to secondary care. We found that all had been appropriately recorded, investigated and when things went wrong with care and treatment, patients were informed and a written explanation was given. The practice had identified learning and shared it with their administrative and clinical teams.

Overview of safety systems and processes

The practice had systems, processes and practices to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice had an appointed safeguarding lead and in their absence the Clinical Director for Invicta Health CIC could be contacted. Safeguarding issues were discussed during their daily clinical and operational meetings and during monthly clinical reviews.
- Staff interviewed had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We found the premises to be clean and tidy. There were cleaning schedules and monitoring systems.
- The practice nurse was the infection prevention and control (IPC) clinical lead. They had an infection prevention control (IPC) policy and staff had received training. The practice had carried out an IPC annual assessment on 16 March 2017. We saw action was taken to address any improvements identified as a result.

There were arrangements for managing medicines and systems to minimise risks to patient safety.

- We asked the practice how they managed Medicines and Health Regulatory products Agency (MHRA) alerts and patient safety alerts. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. The practice told us the clinical pharmacist led on MHRA alerts, conducted searches of the patient record system and shared them with the clinical team, discussed them during daily clinical meetings and monthly meetings.
- We checked patient records to confirm if historical and recent MHRA alerts had been appropriately actioned.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. We checked the prescribing of high risk medicines and found all were being appropriately monitored and prescribed by a GP or a clinical pharmacist.
- Repeat prescriptions were signed before being dispensed to patients and there was a process to help ensure this occurred.
- The practice worked with the local clinical commissioning group medicine management team.
- We checked the storage of the medicines and found staff had recorded temperature discrepancies in medicine fridges and followed appropriate procedure for the safe management of medicines.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed four personnel files for clinical and administrative staff and found appropriate recruitment

Are services safe?

checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy.
- The practice had conducted a general health and safety risk assessment in August 2017. We saw the practice had responded appropriately to risks identified.
- The practice had an up to date fire safety policy and a risk assessment. The practice had appointed and trained fire wardens to help ensure the safe evacuation of the building in the event of an emergency. The last fire drill was held in September 2017.
- All electrical equipment had been checked in January 2017. Clinical equipment had been checked and calibrated in August 2017 to help ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to help ensure enough staff were on duty to meet the needs of patients. For example, the provider shared resources across their sites to cover during planned and unplanned absences.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging facility on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Clinical staff had received basic life support training and update training had been scheduled.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice updated staff on changes to clinical practice during daily and monthly meetings and amended clinical templates to reflect the changes.
- Staff had access to guidelines from NICE on the practice computer systems and via an app on their mobile telephones. They used this information to deliver care and treatment that met patients' needs.
- The practice had also summarised and displayed some national guidance.

Management, monitoring and improving outcomes for people

There were inconsistencies in the accuracy of the registers of patients with specific long-term conditions. The practice used the registers to help ensure patients were receiving appropriate assessments, treatment and monitoring. We found that not all patients with specific long-term conditions were captured by the practice on an appropriate register. For example, we reviewed the care of 15 patients receiving treatment for chronic obstructive pulmonary disease (COPD) and asthma. Records showed that five of these patients were not captured on the practice's relevant register. However, when we checked ten patients receiving diabetic care we found all were appropriately reflected on the register.

The practice had identified a higher prevalence than the local and national averages amongst their patient group for several long-term conditions such as hypertension, diabetes and chronic kidney disease.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). There was no published QOF data available for Invicta Health CIC who had been responsible for the practice for seven months.

There was evidence of quality improvement including clinical audit.

- The practice had a clinical audit programme including; the review of prescribing practices, actioning of Medicines and Health Regulatory products Agency (MHRA) alerts and patient safety alerts and the accurate recording of interventions.
- We reviewed three single cycle clinical audits, these had been aligned to standards, the reports detailed if the standards had been met or improvements were required and action taken to address the risks. Secondary cycles were scheduled to assess if the changes had been embedded into practice and improved standards of care.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- Administrative staff had received in house training and attended local training programmes in order to undertake additional roles such as the coding of clinical data.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. We found staff had received appraisals.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

We found not all information required was easily accessible to staff to enable them to plan and deliver care and treatment in a timely way through the practice's patient record system. For example; We found there were care plans in place for patients with complex care needs.

Are services effective?

(for example, treatment is effective)

However, we found inconsistencies in the coding of the resuscitation status of patients within their care plans. Therefore, there was no assurance it would be appropriately captured and shared with out of hours services.

We reviewed the management of patient test results and found they were being appropriately reviewed and actioned. We found the practice were sharing relevant information in a timely and appropriate manner and following up on referrals to secondary care.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. Meetings took place with other health care professionals (including district nurses, palliative care specialists, practice clinical team) on a monthly basis where care plans were routinely reviewed and updated for patients with complex needs. The group also discussed new cancer diagnoses, unexpected deaths, changes to prescribing practices and learning from incidents.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to clinical commissioning group (CCG) and national averages. For example, rates for the vaccines given to under two year olds ranged from 90% and five year olds from 90%.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to help maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice tried to provide patients with care and treatment from a clinician of the same sex. However, they told us they often experienced a change in clinical personnel with little or no notice, requiring them to reallocate patients to an alternative clinician to ensure they were seen.

We reviewed 22 patient Care Quality Commission comment cards and 32 share your experience emails from patients. Some patients said they felt the clinical staff were polite, supportive and helpful. However, some patients reported feeling rushed during consultations. The practice told us they had introduced 15 minute appointments for patients wishing to discuss multiple concerns.

We spoke with 12 patients including three members of the patient participation group (PPG). They all told us that they were unable to access routine appointments. Comments cards completed by patients confirmed that some staff responded compassionately when they needed help.

Results from the national GP patient survey, published in July 2017, showed the practice was below average for their satisfaction scores on consultations with GPs. For example:

- 74% of respondents said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 76% of respondents said the GP gave them enough time compared to the CCG average of 85% and the national average of 86%.
- 87% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.

- 64% of respondents said the last GP they spoke with was good at treating them with care and concern compared to the CCG average 83% and the national average of 86%.

The practice was comparable with the local and national averages for its satisfaction scores on consultations with nurses. For example:

- 91% of respondents said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 89% of respondents said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 95% of respondents said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 88% of respondents said the last nurse they spoke with was good at treating them with care and concern compared to the CCG average 92% and the national average of 91%.

The practice was below average for its satisfaction scores on the service patients received from the practice team. For example: 65% of respondents said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%. The practice had responded to this by trying to recruit further receptionists and improve their training and understanding of patients needs.

Care planning and involvement in decisions about care and treatment

Patients told us there was a lack of consistent GPs. The practice employed locum GPs as opposed to salaried GPs as they were unable to recruit permanent staff. Some patients told us they did not always feel listened to and did not have sufficient time during a consultation. These concerns were evident in feedback received from patients on the day as well as from comment cards and information received in advance of the inspection on share your experience.

Results from the national GP patient survey, published in July 2017 showed patients reported below local and national averages for their involvement in planning and making decisions about their care and treatment. For example:

Are services caring?

- 69% of respondents said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 59% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average 80% and the national average of 82%.
- 83% of respondents said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 71% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average 86% and the national average of 85%.

We reviewed the patient responses to the NHS Friends and Family questionnaire. In July 2017 the practice received 219 responses. Sixty seven percent or 146 patients stated they were likely to recommend or extremely likely to recommend the practice.

The practice had reviewed the findings of the national GP patient survey and had an action plan to address the concerns and try to improve the care provided to patients and their families. They had increased the reception staff answering calls in the morning and increased the length of some appointments. They had considered the introduction of a call waiting system but this was not feasible due to holding a short term contract.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available.
- The Choose and Book service was used with patients as appropriate. (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.)

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. The practice matron provided additional support for isolated or house-bound patients and the paramedic practitioner was able to respond to immediate care needs.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 78 patients as carers (1% of the practice list). The practice had trained some staff to support patients and direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement, they received signposting on request. Information was available on the practice website to assist bereaved patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an understanding of its patient population profile. Whilst they had a practice population of 6,750 it was weighted for 8,174 patients. This was to reflect the aging demographic and complex needs of their patient population. They told us the service experienced high levels of demand and accepted they needed to continue to make improvements to fully meet the needs of their patients.

- Patients could book appointments in person with the reception team, over the telephone and online. However, patients reported difficulties accessing timely appointments and frustration with the phone lines being constantly engaged resulting in them queuing outside the practice prior to the surgery opening.
- Longer appointments were available on request for patients with a learning disability or multiple needs. However, some patients we spoke with were not aware they could request a longer appointment.
- Home visits were conducted by a practice matron, paramedic practitioner or GP.
- The practice offered daily telephone consultations.
- The practice provided phlebotomy services four mornings a week from 8.20am.
- The practice told us same day appointments were available for children under 12 years and those patients with medical problems that require same day consultation. However, patients told us they were unable to get on the day appointments for ill children. Consultation and treatment rooms were referred to by number and colour to assist patients with poor literacy.
- The practice participated in the electronic prescribing service enabling patients to collect their prescriptions from an elected pharmacy.
- NHS website and a smart phone app were available free to assist patients find the right treatment and signpost services.
- The practice supported patients to register as temporary patients.
- The practice sent text message reminders of appointments for patients who had enrolled on the practice notification system.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop. Although staff were unfamiliar with how to operate it.
- The practice had access to interpretation services.
- The practice was unable to demonstrate awareness of the NHS England Accessible Information Standard to help ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The seating area within reception did not include chairs with arms to assist less able patients.
- A blood pressure machine was available within the reception area.
- The practice conducted tissue viability services including dressing and wound care.
- The clinical pharmacist led on asthma and chronic obstructive pulmonary disease clinics for patients reviewing their medication.
- Specialist appointments were available with the diabetic nurse and the cytology clinic. However, these were currently provided off site at Martello Health Centre in Dymchurch four miles away and a ten minute drive from the practice.
- Some patients reported difficulties seeing a female GP. The practice acknowledged they often experienced a change in personnel with little or no notice.
- A nurse was the named clinician for patients receiving care within residential and nursing homes. They were supported by the practice pharmacist who advised and assisted with reviews of patients medicines.
- There was a designated telephone line for health professionals to contact the practice.

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday. Appointments were from 8.30- 9.15am to 11.40am. The GPs conducted home visits and telephone consultations between 12.30 to 2pm. The paramedic practitioner conducted home visits from 10am to 6pm.

Afternoon clinics were held from 3pm to 6pm. Appointments varied in length either ten or 15 minutes depending on who patients were to see and when their appointment had been booked in for. Three online appointments were available daily released a month in advance in addition to pre-bookable appointments that could be booked up to four weeks in advance. The practice told us urgent appointments were also available for patients that needed them.

Are services responsive to people's needs?

(for example, to feedback?)

The GPs were supported by an extensive clinical team consisting of two practice nurses, a nurse practitioner, assistant practitioner, healthcare assistants, a practice matron, a paramedic practitioner and clinical pharmacists.

The next available appointment with a GP at the practice was in four weeks time on 30 October 2017. The next available appointment with the practice nurse was on the 4 October 2017

The practice told us they experienced high numbers of patients failing to attend for appointments with an average of 5% of patients failing to attend every week. The practice had a policy for the management of such incidents. The policy stated that if a patient failed to attend a booked appointment on two or more occasions they may be required to attend the practice in person to book appointments thereafter. However, the practice told us they had not been actively implementing the policy and had only recently sent out letters to inform patients who failed to attend their appointment of the policy.

We reviewed the accident and emergency attendance data for the practice for July 2017 to assess if the concerns relating to access had increased demand on other local health services. The data was comparable with the local average although the practice did have more patients than the local average brought to hospital by ambulance. However, this may be reflective of their aging population with 1% of their patient list resident in assisted living accommodation.

Results from the national GP patient survey, published in July 2017 showed that patient's satisfaction with how they could access care and treatment was below local and national averages. For example,

- 52% of respondents were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 31% of respondents said they could get through easily to the practice by telephone compared to the CCG average 68% and the national average of 71%.
- 62% of respondents said that the last time they wanted to speak with a GP or nurse they were able to get an appointment compared with the CCG average of 85% and the national average of 84%.

- 56% of respondents said their last appointment was convenient compared with the CCG average of 82% and the national average of 81%.
- 32% of respondents described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 49% of respondents said they didn't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 58%.

The practice had reviewed the findings of the national GP patient survey and had an action plan to address the concerns and try to improve the care provided to patients and their families. They had increased length of some clinical appointments and were trying to recruit to their administrative and diversify their clinical team to improve their clinical response.

Patients told us they could not get appointments and would queue outside the practice prior to it opening to try and get an appointment. The practice had three telephone lines patients could access when calling into the building. Two of the telephone lines were designated for use by the reception team. The third line was used by the reception team during the mornings when there was high demand. However, there was no call waiting or monitoring system to provide data on the demands on the service. This had been considered by the practice but declared not feasible as they held a short term contract.

The practice had a system to assess:

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

Receptionists alerted the clinicians of the home visit request. The clinician told us they regularly reviewed requests and responded to them. This information was also shared with the paramedic practitioner who would often respond to requests on the direction of the GP. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

The practice had received 28 complaints in the last 12 months. We looked at three complaints; one relating to emergency medicines, one to internal procedures and one regarding appointments. We found they had been acknowledged, investigated and responded to. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a patient

complained about the clinical care they received. The practice investigated the clinical care provided to the patient, provided them with an explanation, an apology and proposed further action. They also shared with the patient their policy and procedures to promote understanding and learning between parties.

We reviewed the complaints and incident reporting meeting minutes from September 2017 and the clinical meeting minutes from June 2017 and August 2017. The clinical meetings were attended by the Director of clinical services, Director of nursing services, sessional GPs, members of the nursing team and the paramedic practitioner including administrative support. Complaints were discussed, learning identified and changes made to practice to mitigate the risk of them reoccurring.

Are services well-led?

Good 

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

Our findings

Vision and strategy

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

- The practice had a mission statement and they had involved staff in the drafting and agreement of their values.
- The practice had a clear strategy and supporting business plans.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and the principles of good quality care. This outlined the structures and procedures to help ensure that:

- A comprehensive understanding of the performance of the practice was maintained. We saw the practice kept their performance under constant review through daily morning clinical meetings where they considered clinical workload, as well as prioritising, dividing and delegating tasks effectively.
- The practice has revised practice policies and procedures. These were shared with the practice team promoting learning and best practice.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. For example, nurses had lead roles in key areas in the care of patients in supported living, residential and care homes and the monitoring and management of long-term health conditions.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- The practice accepted they needed to strengthen some of their systems for identifying, recording and managing risks. For example; the practice needed to improve their systems for following up on nonattendance of patients for secondary care appointments and national screening programmes. They also need to improve their understanding of patient demand on the service so those with a clinical need could access timely and appropriate care.

Leadership and culture

On the day of inspection Invicta Health CIC managers demonstrated that they had the experience, to run the practice. However, improvements were still required, and systems and processes needed to be embedded, to identify patient need and respond in a timely manner.

Staff told us the practice had undergone a number of changes and they welcomed a period of stability with the appointment of the interim practice manager.

The provider was aware of and had systems to help ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The provider encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to help ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was a clear leadership structure and staff felt supported by management.

- The practice benefitted from being part of a large organisation enabling the sharing of resources and access to specialist staff. Church Lane Surgery submitted monthly assurance reports to Invicta Health CIC senior management board for discussion and direction.
- The practice accepted they were not meeting patient demand and were reviewing appointment availability and the diversification of the clinical team to improve the responsiveness of the service.
- The practice had tried to secure continuity of care for patients. However, they told us they had been unsuccessful recruiting salaried GPs, or regular locum GPs despite offering enhanced financial packages. The practice was also actively trying to recruit to their administrative team but told us they had also experienced difficulties attracting appropriate applicants. The practice had applied for additional funding to meet patient demand for services.
- We reviewed personnel files and saw the practice had addressed poor clinical performance and/or issues of potential professional misconduct with timeliness, transparency and integrity to safeguard patient care.

Are services well-led?

Good 

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

- The practice management spoke with their team informally daily. They had also introduced monthly multidisciplinary meetings providing an opportunity for all staff to feel listened to, as well as discuss and reflect on concerns and the emotional challenges of their work.

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

The practice acknowledged the importance of receiving feedback from patients and staff. They told us of the difficulties they have experienced trying to build trust and establish a relationship with the community.

- The practice had an active and committed patient participation group (PPG). The PPG and practice reported their relationship had improved over the past three months. Both parties recognised improvements were needed to the service as patients lacked confidence in their ability to access timely care and treatment.
- We reviewed the minutes from the patient participation group meetings held in March 2017 and June 2017. These were comprehensive including discussions on the delivery of services, resources and proposed improvements.
- The practice reviewed monthly NHS Friends and Family test data, complaints and compliments and incidents during team meetings.
- Staff told us they would benefit from a period of stability so changes to the practice could be embedded. They told us they provide feedback individually or as a group to Invicta Health CIC.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The patients consistently told us of their concerns at being unable to access an appropriate service to have their needs and preferences met. Despite the services efforts to secure permanent clinicians they had been unsuccessful at managing patient demand. This was in breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.