Sandgate Road

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sandgate Road on 14 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective and caring services. It was outstanding for providing responsive services. It was also outstanding for providing services for people with long-term conditions. It was good for providing services for the care to older people, families, children and young people, working age people (including those recently retired and students) and 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, 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 allowing all the eight local practices in the Folkestone area to host primary care services, seven days a week, and an urgent home visit service outside of core practice hours.
- 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

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- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, 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 through the work of one GP continues to lead on the introduction of the Pro-Active Care Project into Shepway. Some patients from the practice have already benefitted from this project, which seeks to help patients manage their long term chronic health problems themselves and improve their quality of life. This is achieved through a twelve week programme which seeks to address all aspects of a patient's lifestyle with a view to tackling underlying issues as well as the medical condition itself.

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. This practice was safer than other similar practices and was improving consistently. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Records showed that significant events were discussed with the seven other GP practices in the area through the Invicta challenge fund's Leading Improvements in Safety and Quality (LISQ) meetings. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe.

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. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. All staff had received an appraisal and the personal development plans for all staff. Staff worked with multidisciplinary teams.

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. The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of patients surveyed said the last GP they saw or spoke with was good at treating them with care and concern and 85% of patients said that the last nurse they saw or spoke with was good at treating them with care and concern. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, patients on the care register for end of life care and their families have the direct access number to the

Summary of findings

practice's matrons and the mobile number to contact the nurse. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. 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 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.

Since the Prime Minister's Challenge Fund has been operating, a month by month comparison of A&E attendances and emergency admissions shows a falling trend in A&E attendances and since September 2014 the rate has fallen from 43.4 attendances per 1,000 weighted population to 30.2 attendances per 1,000 weighted population.

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. Data from the National Patient Survey showed that 90% of patients said that the last appointment they got was convenient compared to the national average of 92% and 65% of patients said they got to speak or see the preferred GP of their choice compared to the national average of 60%.

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

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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.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice had established a dedicated team for care of patients over the age of 75. There was a lead matron and dedicated nurse for care and unplanned admissions, who were responsible for care planning. One GP was involved with the clinical commissioning group (CCG) in developing elderly services especially in the community to prevent hospital admissions as there were no beds for GPs to use for step up care. There were community beds for step-down care for patients whose vulnerability meant they needed additional support following discharge from hospital. The aim of this was to reduce hospital re-admission rates.

People with long term conditions

Outstanding

The provider was rated as outstanding for caring overall and this includes for this population group. 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 through the work of one GP continues to lead on the introduction of the Pro-Active Care Project into Shepway. Some patients from the practice have already benefitted from this project, which seeks to help patients manage their long term chronic health problems themselves and improve their quality of life. This is achieved through a twelve week programme which seeks to address all aspects of a patient's lifestyle with a view to tackling underlying issues as well as the medical condition itself. This project was initially trialled by the GP in Liverpool and is now being adopted in Shepway and South East England more widely.

Summary of findings

Families, children and young people

Good

The provider was rated as good for caring overall and this includes for this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. When looking at immunisation rates, overall the practice were higher for all standard childhood immunisations when compared to national average and the area clinical commissioning group (CCG). For example, for the triple vaccine against measles, mumps, and rubella (MMR) for two year old children the practice had achieved 95.9% compared to the CCG rate of 91.4%. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The provider was rated as good for caring overall and this includes for this population group. The needs of the working age population, those recently retired had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The provider was rated as good for caring overall and this includes for this population group. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were 77 patients on the learning disability register and 31 patients had received an annual health check. 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. For example, homeless patients or families in crisis. The practice signposted patients to a local charity that supports the homeless or those threatened with homelessness and the vulnerable in need of support and advice. Patients were also referred a local charity to help them deal with substance misuse. The charity also supported those with learning disabilities and mental health or employment issues. Staff knew how to recognise

Summary of findings

signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good for caring overall and this includes for this population group. The practice kept a register of patients experiencing poor mental health. Records showed 89 out of 132 patients had received an annual review. 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.

Summary of findings

What people who use the service say

All of the 10 patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the 26 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 89% of patients said that their overall experience of the practice was good or very good and that 75% 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 January 2014 demonstrated that most respondents were satisfied with the practice overall.

Outstanding practice

- The practice through the work of one GP continues to lead on the introduction of the Pro-Active Care Project into Shepway. Some patients from the practice have already benefitted from this project, which seeks to help patients manage their long term chronic health problems themselves and improve their quality of life. This is achieved through a twelve week programme which seeks to address all aspects of a patient's lifestyle with a view to tackling underlying issues as well as the medical condition itself.

Sandgate Road

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 Sandgate Road

Sandgate Road surgery is situated in a converted house and located in the residential area of Folkestone. 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 predominantly an elderly population.

A team of six full time GP partners, two salaried GPs, six nurses, two health care assistants, a practice manager, receptionists, medical secretaries and administrative staff provide care and treatment for approximately 10,700 patients. There are four female and four male doctors at the practice to provide patients with a choice of who to see. The practice has been a training practice for doctors to gain experience and higher qualifications in General Practice and family medicine for over 20 years, and currently has one GP registrar. The practice also trained paramedics, to fulfil their role of a paramedic practitioner specialist to provide urgent care home visits for the practice's patients.

Practice nurses are qualified and registered nurses. They can help with health issues such as family planning, healthy living advice, blood pressure checks and dressings. The practice nurses run clinics for long-term health conditions such as asthma or diabetes, minor ailment clinics and carry out cervical smears. Healthcare assistants support the practice nurses with their daily work and carry 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. The practice provides an out-of-hours service to their own patients and appointments are booked via the practice's reception or NHS 111 when the practice is closed.

Appointments are available from 8.30am to 6.30 pm Monday to Friday and extended access appointments were available Monday evenings from 6.30pm to 9pm, and alternate Saturday mornings from 9am to 12 noon. This supported working age patients and children and young people to access appointments outside of normal working hours.

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.

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.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 14 January 2015. During our visit we spoke with seven GPs, the practice manager, two matrons, two practice nurses, four receptionists, two medical secretaries and 10 patients who used the service. We reviewed 26 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 prioritised safety and 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. For example, one member of staff told us how they had responded when a patient collapsed at the surgery. They told us they had reported and recorded the event and were invited to the practice's bi-monthly significant event meeting. Records showed that a full staff meeting was held to review the event that affected all staff and the practice made the decision to purchase a portable screen. The member of staff described the learning from this event and how future procedures in handling this type of situation had been changed. They confirmed that the information was shared with all staff.

We reviewed safety records and incident reports and minutes of meetings where these were discussed over the last year. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. For example, risks associated with carrying out minor surgery when no other clinicians were in the building.

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.

Monthly clinical team meetings were held by at least two of the GPs and staff were invited to attend these

to discuss and learn from significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. As well as discussing significant events with staff, they were discussed with people outside the practice so that ideas for improvement could be shared. Records showed that significant events were discussed with the seven other GP practices in the area through the Invicta challenge fund's Leading Improvements in Safety and Quality (LISQ) meetings.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to ensure these were managed and monitored. We tracked two significant events and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, failure to record a patient's death in medical records resulting in calls to patients to arrange review after death. Changes made were that staff members should ensure that unofficial notifications were followed up and when confirmed recorded in the record. Where patients or their family had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts such as alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated by the senior GP partner to all practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Children who attended A & E were monitored by their registered GP who checked attendance records of the patients. The practice operated on a named GP principle. The named GP would be aware of the wider family issues of the children and would focus on families at risk. The practice had a system and process for following up non-attenders for child immunisations. There was a child care coordinator for immunisations who would contact the parents of the child and arrange an alternative appointment. If there were safeguarding concerns, these would be passed to two nominated administrative support staff who collated safeguarding issues which were overseen by the GP safeguarding lead for the practice.

Practice training records made available to us showed that all staff had received relevant role specific training on

Good

Are services safe?

safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

All patients over the age of 75 years had a named GP, this was their registered GP, and they were notified by letter. The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. The safeguarding lead had received the higher level three safeguarding training. Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern. One GP told us that over the last few years, they had alerted social services to a few problems in nursing homes they had visited and that these had been dealt with. One nursing home had problems with staff recruitment and frequent staff changes/poor quality staff and another nursing home had staff who could not communicate in English. The GP told us that due to their reporting to social services these issues had been resolved and the nursing homes were running well.

The practice offered a chaperone service where a member of staff would be available to accompany patients during intimate examinations at their request (or at the instigation of the clinician involved) and look after a baby or child while their mother was being examined by a GP or nurse. The practice considered that this was a formal role and only nurses or healthcare assistants were allowed to undertake this role and had received the relevant training. All clinical staff had had Disclosure and Barring Service (DBS) clearance (a criminal records check) to help ensure that people who used the service were protected. There was a risk assessment for non-clinical staff to cover those who may come into contact with patients both with others present and when they were on their own whilst working at the practice. Reception staff we spoke with told us that they were not asked to act as a chaperone as there were enough nurses or healthcare assistants available.

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 medicines were kept at the required temperatures. Practice staff were aware of the action to take if the fridge temperature range was not maintained. The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that medicines used in the practice were in date.

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 asthma medicines. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Patients requiring repeat prescriptions were able to request them either on line, in writing or put the repeat prescription paper request in the post box in reception. The practice offered the electronic prescription service, which allowed patients to choose or "nominate" a pharmacy to collect their medicines or appliances from. This system allowed the patient to have their repeat medication sent directly to the address of their choice each month from a specialist pharmacy warehouse. The community pharmacists would liaise with the patient and GP to ensure the patient received the correct medication on time each month. The practice did not routinely take prescription requests over the telephone. For patients who were housebound local pharmacies provided a delivery service.

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. Patients we spoke

with told us they always found the practice clean and had no concerns about cleanliness or infection control. 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 infection control lead nurse had carried out an audit in November 2014 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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 in order to comply with the practice's infection control policy. There was a policy for needle stick injuries and staff knew what to do if this occurred. There were arrangements in place for the safe disposal of clinical waste and sharps,

such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

The practice did not have a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We spoke with the practice manager who confirmed that a risk assessment had been undertaken and that the practice were planning to carry out a check by an external company to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this had been carried out in December 2014. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as weighing scales. Emergency equipment such as the two defibrillators (electronic devices that apply an electric shock to restore the rhythm of an irregular heart) were available for use in a medical emergency. We saw that the equipment was checked monthly to ensure it was in working order and fit for purpose.

Staffing and recruitment

We saw evidence that health professionals, such as doctors and nurses, were registered with their appropriate professional body and so considered fit to practice. There was a system in place to monitor health professionals' registrations were in date. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, 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.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice

also had a health and safety policy and had completed Control of Substances Hazardous to Health (COSHH) risk

assessments. The practice had fire procedures, we saw a certificate of maintenance and servicing last carried out in January 2014 and a fire risk assessment carried out by an external company in January 2013.

We saw that staff were able to identify and respond to changing risks to patients over including deteriorating health and well-being. The practice used a nationally recognised patient safety framework to enable them to identify patients at risk. GPs carried out mental health assessment a review of young people who were in residential care and weekly reviews in local nursing homes they provided care for. This enabled them to identify risks to patients who had a deterioration in health. Staff at the practice told us that the GPs always responded quickly to any requests for an urgent visit. There were emergency processes in place for identifying acutely ill children and young people and children were provided with on the day appointments when needed.

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 two automated external defibrillators (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 a heating company to contact in the event of failure of the heating system.

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 and from local commissioners. Minutes reviewed demonstrated that new guidelines were discussed at monthly clinical team meetings and QOF meetings.

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 led in specialist clinical areas such as diabetes and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner 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 high blood pressure 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.

The practice held quarterly multi-disciplinary meetings between the practice, community nurses based at the practice 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 16 patients and alerts within the clinical computer system making clinical staff aware of their additional needs. The practice was working on a dementia register to ensure that they had recorded all 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. 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.

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 national performance

measurement tool. An example of this was following an alert from the Medicines and Healthcare Products

Regulatory Agency (MHRA). An example of this was the prescribing of medicines for the treatment of subclinical hyperthyroidism, in relation to coronary heart disease. We saw that an audit had been completed which identified issues around recording the appropriate duration the medicine was to be prescribed for. We saw that changes were made to the way the prescription instructions were written and recorded to ensure patients received the medicine in line with national guidelines

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients had

Good

Are services effective?

(for example, treatment is effective)

achieved a score of 872.36 points out of a maximum of 900 equating to 96.9%. For example, 99% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (COPD) and palliative care. 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 practice also participated in local benchmarking run by the CCG. This is 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 such areas as child immunisation, antibiotic prescribing and hospital referral rates. Immunisation rates were relatively high for all standard childhood immunisations. When looking at immunisation rates, overall the practice were higher for all standard childhood immunisations when compared to national average and the area clinical commissioning group (CCG). For example, for the triple vaccine against measles, mumps, and rubella (MMR) for two year old children the practice had achieved 95.9% compared to the CCG rate of 91.4%.

Effective staffing

Practice staff included medical, nursing, managerial, community support, cleaning and administrative staff. We reviewed staff training records and saw that all staff were up to date or in the process of attending essential training such as annual basic life support and safeguarding vulnerable adults and children. We noted a good skill mix among the doctors with four GPs having additional diplomas from the Royal College of Obstetricians and Gynaecologists.

All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

We were shown evidence that staff in all roles were provided with a thorough induction process. Staff had access to a range of training opportunities. We looked at records which showed that all staff training was up to date or in the process of being completed. All staff undertook annual appraisals that identified learning needs from which action plans were documented. Interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. An example of this was one practice nurse told us how they had been supported and funded to complete a degree. All current nursing staff had access to accredited modules for training at a local university as part of a degree pathway. The practice currently hosted a student nurse placement to support a degree course being run by a local university.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines and cervical cytology. Those with extended roles, for example those staff seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes 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 patients' needs and manage complex cases. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services 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 administration team consisted of an office manager, medical secretary and administration

Good

Are services effective?

(for example, treatment is effective)

staff who were responsible for scanning hospital letters and the summarising of records. We spoke with two members of this team who demonstrated a clear knowledge of their role and responsibilities in ensuring that the information received was processed and forwarded to the appropriate GP in a timely manner. The GP who saw these documents and results was responsible for the action required.

The practice held monthly multidisciplinary team meetings to discuss the needs of patients with complex health needs such as terminally ill patients. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Minutes from multi-disciplinary meetings between the practice, palliative care nurses and district nurses demonstrated that patients who were receiving end of life care were provided with appropriately co-ordinated care. The practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

The practice worked closely with other services in the region to ensure that the care they provided to patients was effective. The practice also engaged with the local CCG consisting of 31 practices to look at GP practice effectiveness in meeting the needs of patients. The GPs worked with a local nursing home to provide a rehabilitation service. This included step down beds for older patients whose vulnerability meant they needed additional support following discharge from hospital.

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 60 referrals in the last six months through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use. The practice has also signed up to the electronic Summary Care Record and this is fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). The practice maintained the Summary Care Record for patients. The practice also respects the wishes of any patient who wishes to opt out of the Summary Care Record and codes this choice in their medical record. The practice has instigated and promoted the Patient Online Access system which allowed patients to book routine appointments, order repeat prescriptions and provided access to summary information of their patient record.

The practice had systems to provide staff with the information they needed. Staff used the EMIS web

electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system and the practice had commissioned additional support from an external IT specialist within the area to support staff. 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 (MCA) and their duties in fulfilling it. Records showed that staff had received training in the MCA through the practice's on-line training package. 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 and were involved in developing their own individual care plans. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competency when obtaining consent from children and young people. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. An example of this was that for all minor surgical procedures, a patient's consent was documented with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

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 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 381 patients in this age group took up the offer of the health check.

Through analysis of data held on the practice's computer system, the practice had identified groups of 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 31 out of 77 had received an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Over 342 patients with chronic disease and 1,502 other patients had been given smoking cessation advice. Evidence of evaluation of the effectiveness of this service was not available on the day of our inspection. The practice participated in the local programme for mammograms which was done on a three year cycle. They also participated in the national programme for bowel screening and discussed this with patients as appropriate.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. For example, for the triple vaccine against measles, mumps, and rubella (MMR) for two year old children the practice had achieved 95.9% compared to the CCG rate of 91.4%.

Other health promotion and prevention services offered by the practice included family planning services including well woman clinics cervical screening and a general discussion on all aspects of women's health including lifestyle. Well man clinics, a general lifestyle check including blood pressure monitoring, lung function test and advice on diet, exercise and other male health issues.

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 the National Patient Survey and a survey of over 150 patients undertaken by the practice's Patient Participation Group (PPG) in January 2014. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. 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 that 89% of respondents said that their overall experience was good or very good and 75% of respondents would recommend the surgery. These results were above the local Clinical Commissioning Group (CCG) average. The PPG survey supported these findings with satisfaction levels of 95% for overall experience. The practice was also within the CCG average for its satisfaction scores on consultations with doctors and nurses with 85% of practice respondents saying the GP was good at listening to them compared to the local CCG average of 87% and 82% saying the GP gave them enough time compared to the local CCG average of 86%.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were always helpful, professional and caring. They said staff 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. Most patients told us they had no problems getting through to the practice on the telephone to make an appointment. This was supported by the National Patient survey with 76% of respondents finding it easy to get through to the practice by telephone. This was within the local CCG average.

We spoke with 10 patients on the day of our inspection. 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. 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. There was a notice in place stating only one patient at a time was to speak with the receptionist which ensured there was only one patient at the reception desk at any time. This avoided patient queues at the reception desk and prevented patients from overhearing potentially private conversations. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us 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 or reception manager. The reception manager and the practice manager told us they would investigate these and any learning identified would be shared with staff.

Patients who were away from home could receive healthcare by applying to the practice for services as a "temporary resident".

Care planning and involvement in decisions about care and treatment

The National 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, 84% of patients felt the GP was good at explaining treatment and results with 81% of practice respondents saying that the GP involved them in care decisions. The results from the PPG satisfaction survey showed that 81% of respondents said they were sufficiently involved in making decisions about their care and 71% said that the GP was good at explaining treatment and results.

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. Most patients registered at the practice had English as their first language. Staff told us how they accessed translation services if a patient did not have English as a first language.

There were 77 patients on the practice's learning disabilities register. We saw that 31 patients had

received an annual health review carried out using the Cardiff Health Check template to ensure a systematic review of their health and medication. At the end of the review the patient was provided with a health action plan which was agreed with them. The practice kept a register of patients experiencing poor mental health. Records showed 89 out of 132 patients had received an annual review. A care plan template was available to enable GPs to plan the care for these patients.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of patients surveyed said the last GP they saw or spoke with was good at treating them with care and concern and 85% of patients said that the last nurse they saw or spoke with was good at treating them with care and concern. This result was below the CCG regional average of 92%. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer and identified patients that were cared for. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Outstanding ☆

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 people'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 through the work of one GP continued to lead on the introduction of the Pro-Active Care Project into Shepway. Some patients from the practice had already benefitted from this project, which sought to help patients manage their long term chronic health problems themselves and improve their quality of life. This was achieved through a twelve week programme which sought to address all aspects of a patient's lifestyle with a view to tackling underlying issues as well as the medical condition itself. This project was initially trialled by the GP in Liverpool and was now being adopted in Shepway and South East England more widely. Due of the success of the project, it will be rolled out to the Dover, Deal and Romney Marsh areas. We were shown publications from medical journals, South Kent Coast CCG on line information publication and an article that was published on the Department of Health website about the initiative in Kent giving people with long-term conditions ways of improving their health and keeping them out of hospital.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, orthopaedic pathways and emotional wellbeing strategy for patients.

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, through the PPG survey it was identified that parking, in particular provision for those, who due to limited mobility found it hard to get from a car parked in the adjacent streets to the practice. An action plan was put in place to improve the access and a drop off and collection bay for patients with mobility difficulties visiting the surgery who were unable to park nearby. On the day of our inspection we saw that these had been provided. There were improved facilities for those in wheelchairs and mobility scooters at the reception desk and facilities provided for patients to discuss confidential matters with receptionist when necessary.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had initiated positive service improvements for its patients. To meet the needs of patients whose circumstances may make them vulnerable, the practice had identified a lead GP for patients with learning disabilities. Patients with learning disabilities were offered an annual health assessment and provided with easy read information to support them to access services. For patients who were house bound, home visits were provided to reduce loneliness and social isolation.

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. For example, homeless patients or families in crisis. The practice signposted patients to a local charity that supported the homeless or those threatened with homelessness and the vulnerable in need of support and advice. Patients were also referred to a local charity to help them deal with substance misuse. The charity also supported those with learning disabilities and mental health or employment issues.

The premises and services had been adapted to meet the needs of patients with disabilities. There was disabled parking available and step free access to the semi-automatic doors. The practice was situated on the ground floor of the building with easy access to the reception area. 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.

Access to the service

Appointments were available from 8.30am to 6.30 pm Monday to Friday and extended access appointments were available Monday evenings from 6.30pm to 9pm, and alternate Saturday mornings from 9am to 12noon. This supported working age patients and children and young

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

people to access appointments outside of normal working hours. We saw that the reception manager carried out regular audits to ensure that there were enough appointments to meet patient need.

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 on-line. 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 their call was diverted directly through to the Out of Hours service, NHS111. Information on the out of hours service was provided to patients in the waiting room and through the practice's website.

The practice was 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 were booked via the practice's reception or NHS 111.

Since the Prime Minister's Challenge Fund has been operating, the practice has undertaken a month by month comparison of A&E attendances and emergency admissions that shows a falling trend in A&E attendances. Since September 2014 the rate has fallen from 43.4 attendances per 1,000 weighted population to 30.2 attendances per 1,000 weighted population.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. 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. Information on how to complain was displayed in the waiting room and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 18 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 the length of their wait to get through on the phone to cancel an appointment. We saw that the complaint had been analysed and numbers of staff taking calls increased during busy times of the day, to prevent the incident reoccurring.

There was evidence to show that the practice reviewed complaints annually to detect themes or trends. 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. The practice manager showed us an audit of the complaints and staff told us they were informed of the results of this audit through management and group team meetings.

The practice shared complaints outcomes with the Kent and Medway Commissioning Support Unit and reports annually. Complaints trends were also shared with the Patient Participation Group and inform decision on preparation for the practice's annual survey. Complaint trends were also discussed with other practice managers within the local CCG. Where a complaint involved another organisation, for example a hospital department, the practice would liaise with that organisation in order to resolve all aspects of the complaint. Where the complaint only related to that organisation, the practice would seek permission from the patient to pass on the complaint to that other organisation for a response. The practice also shared information with NHS England when patients had chosen to pass complaints through that body rather than deal with the practice directly.

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 philosophy included recognising patients lifelong health needs and they aimed to treat patients as individuals, combining excellent up-to-date innovative skills with traditional service values. This was underpinned by their practice values which included; providing high quality general medical services to patients ensuring patients were at the centre of everything they did; providing these services in a safe, professional and comfortable environment through continual updating of clinical skills and training specific to staffs' individual needs.

The practice had also developed core values to be shared among partners and staff. These included to be the best GP practice; to ensure an enjoyable place to work with regard to staff relationships and friendships; job satisfaction; pleasant working environment; positive feedback; good communication links and networks and manageable workloads.

We spoke with 19 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us there was an open culture within the practice and that their opinions were listened to, respected and acted on.

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 17 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 17 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 19 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 monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice held partners' meetings and monthly operational management meetings to discuss governance issues. Regular staff meetings took place where information was shared with partners and other staff groups. Minutes from the meetings demonstrated that performance, quality and risks had been discussed.

The practice used clinical audits to monitor quality and to identify if action was required to improve outcomes for patients. The practice had completed a number of clinical audits, for example Pro-Active Care (PAC), is a form of integrated care that involves a multidisciplinary team, the members of which collectively evaluate a patient's condition and decide upon their treatment. The study looked at the impact of PAC on the local health economies. We saw that the audit had been completed and evaluated with a view to expanding the programme to more patients.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as loss of domestic services or information technology; Control of Substances Hazardous to Health (COSHH); fire safety and buildings maintenance.

Leadership, openness and transparency

Minutes of team meetings showed that they were held 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and information governance which were in place to support staff. Staff showed us how they accessed these policies if they needed to refer to them. The practice had a whistle blowing policy which was available to all staff via the computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through their Patient Participation Group (PPG), patient surveys, complaints and compliment cards. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive. We looked at the results of the practice's annual patient survey and saw that patient satisfaction in seeing their GP of choice was 95%.

The practice had an active PPG. We spoke with a representative during our inspection who told us that the group was listened to and worked closely with the practice. The PPG contained 11 representatives aged 50 to 70 years of age. There was a mixture of male and female members. The PPG held six general meetings a year and an annual general meeting each April. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. The PPG worked with the practice to identify the need for additional resources and equipment.

The practice had gathered feedback from staff through staff meetings, appraisals, team appraisals and discussions. 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.

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 five 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.

The practice had been a GP training practice for GP Registrars (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students for over 20 years. There was a lead GP responsible for the induction and overseeing of the training for GP Registrars and medical students. The ethos of learning and improvement in terms of knowledge and skills was evident throughout the inspection. The practice al also trained paramedics, to fulfil their role of a paramedic practitioner specialist to provide urgent care home visits for the practice's patients.

The practice had completed reviews of significant events and other incidents and shared with staff through monthly significant events meetings to ensure the practice improved outcomes for patients. For example, following a patient being given an out of date injection, systems had been changed to prevent this from happening again. The practice produced a protocol to ensure that this could not happen again which was shared with the practice nurses.