Faversham Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 Faversham Medical Practice on 26 October 2015. Overall the practice is rated as good. 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.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients often found it difficult to get through to the practice by telephone. However once through to the practice patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

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We saw areas of outstanding practice namely:

Summary of findings

- The practice had GP retained beds at the local cottage hospital and these were serviced by practice staff and used to provide personalised care to patients who would otherwise be managed in the general district hospital.
- The practice had effective links with a local charity that supported elderly people and responded to requests from them for appointments for patients they supported.
- The practice was involved in the provision of drug rehabilitation services through a shared clinic with a charitable organisation.
- The practice had worked with commissioners to secure the contract to run the local minor injuries unit. This unit had been in danger of closing and being lost to the community. The practice was continuing to develop and increase services at the unit for example there were plans to provide x-ray services which had not been previously available at the unit.
- During the winter of 2014 the practice had run weekend surgeries to provide additional access to primary care for patients to assist them in avoiding admission to the local hospitals. A similar service was due to open in November which was intended to achieve the same outcome.

However, there was an area where the practice needs to make improvements namely.

- Review the process for dealing with medical alerts to help ensure that the alerts were actioned, as required, by the individuals to whom they were sent.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

There was an effective system for reporting and recording significant events. Lessons were shared to make sure action was taken to improve safety in the practice. When there are unintended or unexpected safety incidents, people received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were above average for the locality. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for most staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.

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 several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs. For example it had secured the contract for the running of the local minor injuries unit which would otherwise have been closed. There were innovative approaches to

Summary of findings

providing integrated person-centred care; the practice had GP retained beds at the local cottage hospital, these were serviced by practice staff and used to provide personalised care to patients who would otherwise be managed in the general district hospital.

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). For example suggestions from the PPG had influenced the way the practice staffed the reception desk.

People can access appointments and services in a way and at a time that suits them; the practice had run weekend surgeries, during the winter months, to provide additional access to primary care for patients to assist them in avoiding admission to the local hospital.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice 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 to deliver high quality care and promote good outcomes for patients. Most staff were clear about the vision and their responsibilities in relation to this although some staff felt that there was isolation between the different departments and that more could be done to improve communication between them. 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 was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents The practice actively sought feedback from staff and patients, which it acted on. The patient participation group was active. There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding 

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. It was responsive to the needs of older people, and offered home visits and urgent appointments for them when necessary. The practice had effective links with a local charity that supported elderly people and responded to requests from the charity for appointments for patients. The practice used recognised tools such as the PRISMA questionnaire to assess the presence of frailty in the elderly.

People with long term conditions

Good 

The practice is rated as good for the care of people with long-term conditions.

GPs and nurses had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Quality and Outcomes Framework (QOF is a system intended to improve the quality of general practice and reward good practice) results for the practice are very high. Longer appointments and home visits were available when needed. Patients on the long term conditions registers received an annual review to check that their health and medicines 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.

Families, children and young people

Good 

The practice is rated as good for the care of families, children and young people.

There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable to the national performance for all standard childhood immunisations. Cervical screening results were in line with the national standards. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice offered coordinated services for families, for example postnatal reviews were offered at the same time as child immunisation to negate multiple visits to the practice.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice had a register of patients living in vulnerable circumstances. It offered longer appointments for people with a learning disability and those using translation services. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in 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. The practice was involved in the provision of drug rehabilitation services through a shared clinic with a charitable organisation.

People experiencing poor mental health (including people with dementia)

Good

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

Eighty four per cent of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had a good understanding of how to support people with mental health needs and dementia.

Summary of findings

What people who use the service say

The most recent national GP patient survey results showed the practice results were either marginally or considerably below local and national averages. The survey comprised 124 returned questionnaires. This was approximately 0.9% of the practice population.

- 68% found it easy to get through to this surgery by phone compared to a CCG average of 80% and a national average of 73%.
- 84% found the receptionists at this surgery helpful (CCG average 88%, national average 87%).
- 84% were able to get an appointment to see or speak to someone the last time they tried (CCG average 90%, national average 85%).
- 89% said the last appointment they got was convenient (CCG average 96%, national average 92%).
- 64% described their experience of making an appointment as good (CCG average 80%, national average 73%).
- 57% usually waited 15 minutes or less after their appointment time to be seen (CCG average 66%, national average 67%).

We spoke with four patients during the inspection and there were 17 comment cards left by patients. Of these cards15 were positive. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two comment cards were negative and highlighted the difficulty of getting through to the practice on the telephone.. All the patients said that they were happy with the care they received and thought that staff were approachable, committed and caring. We received some specific positive comments about the diagnostic skills of GPs.

Areas for improvement

Action the service SHOULD take to improve

- Review the process for dealing with medical alerts to help ensure that the alerts were actioned, as required, by the individuals to whom they were sent.

Outstanding practice

- The practice had access to GP retained beds at the local cottage hospital and these were used to provide personalised care to patients who would otherwise, often, be managed in the general district hospital.
- The practice had secured the contract for the running of the local minor injuries unit which would otherwise have been closed.
- The practice had effective links with a local charity that supported elderly people and responded to requests from them for appointments for patients they supported.
- The practice was involved in the provision of drug rehabilitation services through a shared clinic with a charitable organisation.
- The practice had worked with commissioners to secure the contract to run the local minor injuries unit. This unit had been in danger of closing and being lost to the community. The practice was continuing to develop and increase services at the unit for example there were plans to provide x-ray services which had not been previously available at the unit.
- During the winter of 2014 the practice had run weekend surgeries to provide additional access to primary care for patients to assist them in avoiding admission to the local hospitals. A similar service was due to open in November which was intended to achieve the same outcome.

Faversham Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Faversham Medical Practice

Faversham Medical Practice is a GP practice located in the centre of Faversham Kent and provides care for approximately 14000 patients. The practice was formed by the merger of two practices "Cross Lane Medical Practice" and "Dr Logan and Partners". The partnerships merged on 1 July 2014 but the practice lists were formally merged on 1 October 2014. The age demographics of the practice are close to the national averages though there is marginally less deprivation than nationally.

There are eight GP partners, three female and five male, as well as one salaried GP. There are five female nurses (three nurse practitioners and two practice nurses) and three female healthcare assistants. The practice has a general medical services contract with NHS England for delivering primary care services to local communities. It offers enhanced services for example, offering services for patients with a learning disability and minor surgery. The practice is an approved GP training and teaching practice training undergraduates and foundation doctors. During each year there are normally three GP registrars training in practice. A registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. The practice also provides training for medical students.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8.40am to 11.40am every morning and 3.30pm and 5.30pm each afternoon. There are no extended hours surgeries as such but the practice does run the minor injuries unit, in the same building, which is open from 8am to 8pm seven days a week. Services are delivered from;

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The practice has opted out of providing out-of-hours services to their own patients. Care is provided by Integrated Care 24. There is information available to patients on how to access out of hours care.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

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. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 26 October 2015. During our visit we spoke with a range of staff including GP partners, nursing staff, receptionists and administrators. We spoke with patients who used the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia).

Good

Are services safe?

Our findings

Safe track record and learning

We reviewed clinical and other incidents that had occurred at the practice during the last 12 months. There were systems for the reporting, recording and monitoring significant events. Incidents were discussed at quarterly meetings with GPs, nurses and the practice manager and changes made. For example as result of an incident the practice saw that emergency medicines were not all stored in the same place, where they were easily accessible. They made changes to the storage arrangements and staff were informed of the changes.

There was a process for dealing with safety alerts. These were received by the practice manager. We looked at safety alerts over the previous year and saw that they had been received, recorded and circulated to the individual staff affected by the alert. However there was no process to ensure that the alerts were actioned by the individuals as required.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to help keep people safe.

There were arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Policies showed who to contact for further guidance if staff had concerns about a patients' welfare. There were notices directing staff who to contact in order to report such matters. There was a lead GP for safeguarding who attended safeguarding meetings when appropriate. All GPs had completed child safeguarding to level three.

There were notices in the waiting room and in consultation rooms, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones had received a disclosure and barring check (DBS). These 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 vulnerable adults.

There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy and related risk assessments. The practice did not own the building and some processes such as building risk assessments and fire and legionella risk assessments were managed by the building landlord. The practice manager met with the landlord regularly to discuss building safety matters. In other areas, such as the maintenance of electrical equipment, the practice checked to ensure the equipment was safe to use. Clinical equipment was checked to ensure it was working properly and was correctly calibrated.

Medicines in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a policy to help ensure that medicines were kept at the required temperatures and which described the action to take in the event of a power failure. We checked records and medicines were kept within the correct temperature range. The practice checked medicines were within their expiry date and suitable for use. The medicines we checked were all within date. Prescriptions were reviewed and signed by a GP before they were given to the patient. Regular medical and prescribing reviews were carried out with the support of the clinical commissioning group to help ensure the practice was prescribing in line with best practice guidelines. Prescription 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.

The premises were clean and tidy. There were cleaning schedules and cleaning records were kept by the building landlord, where the practice had raised issues about cleanliness these had been addressed by the landlord quickly and effectively. Patients said that the practice was clean and had no concerns about cleanliness or infection control. The practice had a lead nurse for infection control who was able to provide advice to the practice infection control and carry out staff training. All the staff we spoke with knew who the lead was. The lead had carried out an infection control audit within the last 12 months. This had identified that sterile packages were being kept at floor level in a storage room and these were now stored on shelving.

Records contained evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at staff files and saw that there was proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a policy that set out the standards for recruiting staff.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). All the staff we spoke with knew the location of the equipment and we saw that it was checked regularly.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The plans contained contact details for staff to refer to, for example, contact details of utility companies, local authority departments, electricians and other trades.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) guidelines and had systems to ensure GPs and nurses were kept up to date. The practice had access to guidelines from NICE and guidelines about other local practice such as local referral pathways. The practice used the guidelines, for example by using ambulatory blood pressure monitoring for the diagnosis of patients where hypertension (raised blood pressure) was suspected. The practice used other recognised tools such as the PRISMA questionnaire to assess the presence of frailty in the elderly.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had been created out of the merger of two practices, Cross Lane medical practice and Dr Logan and partners. Both of the practices had achieved high QOF scores (high scores being a reflection of better practice). However because of the merger there were no definitive results available for the new practice. This had been discussed with NHS England, who administer the payments for QOF, and they determined that an aggregate score for the new practice of 99% properly reflected the practice's achievement.

It was possible to identify the results of the practices separately. For example for one annual test undertaken for patients with diabetes Cross Lane achieved 91% and Dr Logan 93% compared with an average for the local clinical commissioning group of 89%. Similarly the figures for patients diagnosed with mental health illness, who had had an annual care plan, the figures were 93% and 97% compared with the local figure of 88%. The results for patients with hypertension, whose level of physical activity had been assessed in the previous twelve months, were respectively 94% and 79% against a local average of 78%. This high standard of outcomes was generally reflected across the range of outcomes measured.

There were clinical leads for various long term conditions with dedicated clinics to support patients to manage their illness. We saw examples of personalised care such as the practice providing a patient with an infusion at the local cottage hospital thus avoiding the patient having to make a weekly visit to the general district hospital. The practice was involved in the provision of drug rehabilitation services through a shared clinic with a charitable organisation.

There were regular clinical audits and we looked at two in detail. One related to the use of anti-coagulant medicines and a second to urinary tract infection. In both cases there had been an initial collection of data, this had been analysed and the results discussed in practice meetings, Measures had been taken to improve the results for patients and there had been a second, or sometimes further cycles, of data collection to ensure that the improvement was sustained. There was no audit plan for the practice as a whole so audits were not all coordinated or targeted towards specific practice issues.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Records showed there was an overall training plan and mandatory training such as information governance, basic life support and infection prevention control had been completed by all staff. Where there were gaps in the training the practice had identified these and taken measures to help ensure the training was carried out. The practice had an induction programme for newly appointed staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

There was a wide skill mix among the doctors with GPs having qualifications in child health, sexual and reproductive health, family planning, nutritional medicine and surgery. Some of the GPs were GP trainers; that is qualified to train other doctors to become GPs. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation.

Most staff had had an annual appraisal and all the staff we spoke with about their appraisal said that they had found the process useful. They said they had used it to identify training needs and it provided an opportunity for staff to discuss their performance with their manager. Some administration staff had not had an appraisal, however the practice were aware of this and were addressing it.

Good

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and other correspondence both electronically, by fax and by post. Staff knew their responsibilities in dealing with any issues arising from these communications. There was a system whereby staff were partnered with other colleagues so that, if one person was on leave or absent, there was another member of staff allocated to check their outstanding work.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan care and treatment. This included when people moved between services. The practice had 25 GP retained beds at the local cottage hospital, these were serviced by practice staff. We saw examples of how these were used to provide personalised care to, often elderly, patients who would otherwise be managed in the general district hospital. The practice had effective links with a local charity that supported elderly people and responded to requests from them for appointments for patients they supported.

Consent to care and treatment

Patients' consent to care and treatment was always obtained in accordance with legislation and guidance. The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination including written and verbal consent. There was a specific process for obtaining consent to intrusive procedures such as minor surgery and practice used a nationally recognised form, adapted to the practice's needs to record this.

GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. For example, as part of a national initiative to prevent unplanned admissions to hospital, the practice had identified the 2% of patients who were most vulnerable. Each of these had an individual care plan and a GP allocated to their care.

The practice's uptake for the cervical screening programme could not be directly identified but the results of the two practices (Cross Lane and Dr Logan) were 83% and 80% respectively. This is in line with the national results (82.2%). Childhood immunisation rates were comparable to local and national averages.

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

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 GP Patient Survey. We spoke with patients and read the comment cards that patients had completed. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Members of staff were courteous and helpful to patients and treated people with dignity and respect. Patient confidentiality was respected. There was a private area where patients could talk to staff if they wished. All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms and it was not possible to overhear what was being said in them.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice results were in line with those nationally for its satisfaction scores on consultations with doctors and nurses.

The survey results showed that;

- 87% said the GP was good at listening to them compared to the CCG average of 93% and national average of 89%.When asked the same question about nursing staff 88% said the nurses were good at listening to them compared to the CCG average of 93% and national average of 91%.
- 88% said the GP the GP gave them enough time compared to the CCG average of 90% and national average of 87%.When asked the same question about nursing staff 92% said the nurses were good at listening to them compared to the CCG average of 93% and national average of 92%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.When asked the same question about nursing staff 98% said they had confidence and trust in the last nurse they saw were good at listening to them compared to the CCG average of 99% and national average of 97%.
- 84% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

There were 17 comment cards left by patients. Of these 15 were positive. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two comment cards were negative and highlighted the difficulty of getting through to the practice on the telephone.

Care planning and involvement in decisions about care and treatment

The patient survey information showed patients responded positively to questions about their involvement in planning and making decisions about their care as well as treatment. The practice results were in line with those nationally. Data from the national patient survey showed that:

- 93% said the GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.When asked the same question about nursing staff 95% were positive about the nursing staff compared to the CCG average of 91% and national average of 90%.
- 81% said the GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%.When asked the same question about nursing staff 81% were positive about the nursing staff compared to the CCG average of 87% and national average of 85%.

There were translation services were available for patients who needed them and there were notices in the reception to this effect.

Patient and carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access services such as those related to specific disabilities. There were notices in the patient waiting room and patient website that directed patients to support groups and organisations for carers. There was a protocol for staff to follow to help identify carers.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had worked with commissioners to secure the contract to run the local minor injuries unit. This unit had been in danger of closing and being lost to the community. The practice was continuing to develop and increase services at the unit for example there were plans to provide x-ray services which had not been previously available at the unit.

There was an active patient participation group (PPG) which met regularly and worked with the practice to improve services. We spoke with the chair of the PPG who said that the practice was committed to having an active and representative group. The practice supported the group with administrative and secretarial tasks. There were plans to introduce a regular newsletter to keep patients informed about changes to the practice and other local health services. Minutes of PPG meetings showed that the acted on suggestions from the group for example it had influenced how the practice staffed the reception area. GP partners regularly attended the PPG meetings.

During the previous winter the practice had run weekend surgeries to provide additional access to primary care for patients to assist them in avoiding admission to the local hospitals. A similar service was due to open in November which was intended to achieve the same outcome.

There were longer appointments available for people with a learning disability and those who needed them for example patients who used translation services. There were home visits for older patients or those in care homes. We noted a high level of home visits by GPs. Same day appointments were available for children and those with serious medical conditions. The practice offered coordinated services for families, for example postnatal reviews were offered at the same time as child immunisation to negate multiple visits to the practice.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.40am to 11.40am every morning and 3.30pm and 5.30pm each afternoon. There were no extended hours surgeries as such but the practice did run the minor injuries unit, in the same building, which was open from 8am to 8pm seven days a week. In addition to pre-bookable appointments urgent appointments were also available for people that needed them. Patients told us that they were able to get appointments at short notice. We heard a patient ring for an appointment at 4.50pm and received an appointment for just after 9am the following day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages. People told us on the day that they were able to get appointments when they needed them.

- 70% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 68% patients said they could get through easily to the surgery by phone compared to the CCG average of 80% and national average of 73%.

The practice were aware of the problems patients had getting through on the telephone, however the telephone system was controlled by the building landlord, NHS property services. The practice had been asking for several years for the telephone system to be upgraded, but it had not been done.

Listening and learning from concerns and complaints

There was a complaints policy which included timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system on the practice website but there was no information in the reception area about complaints.

We looked at a range of complaints received in the last 12 months. The practice was aware of trends in complaints and ensured that this was shared with staff. For example the practice expected and saw an increase in complaints when the two practices merged. Out of 55 complaints 33 related to administrative issues. The practice was able to show that the rate of receipt of complaints was falling.

The records showed that patients were involved in discussions, informed about the actions taken and were usually satisfied with the outcome. The minutes of staff meetings also reflected learning from complaints.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Complainants were offered an apology where the circumstances warranted it. Complainants were referred to the Health and Parliamentary Ombudsman if the matter could not be resolved and a note of this made on the complaint's record.

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 using multi-disciplinary teams to provide local responsive personalised services. The practice was also focused on safeguarding and expanding local services. This was evident through their commitment to the minor injuries unit for the town which they had recently secured a contract to run. The practice was also part of the local multispecialty community provider (MCP) vanguard which aimed to provide a wider range of care using a broader range of health professionals. These initiatives are in line with the strategic concepts contained in NHS Five Year Forward View. These objectives were supported by a robust business plan.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

There were practice specific policies that were available to all staff. There was evidence that the policies had been read by staff. We looked at some of these including recruitment, chaperoning, safeguarding, bereavement and complaints they were in date and reviewed when necessary.

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 GPs with responsibility for safeguarding and performance against the quality and outcomes framework (QOF) so that there was a comprehensive understanding of the performance of the practice.

The practice conducted clinical and internal audits to monitor quality and to make improvements. There had been a three year audit of the prevention of pulmonary embolism which had resulted in improved rates of diagnosis. There had been prescribing audits, carried out in partnership with the local clinical commissioning group which identified some outliers in prescribing and that was due to be discussed at a clinical meeting. There was however no overall audit plan. Most audit activity was undertaken in reaction to events.

The practice had arrangements for identifying, recording and managing risks. These included fire, flood and damage to the building. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented.

Leadership, openness and transparency

There was a clear staffing structure and staff were aware of their own roles and responsibilities. Most staff felt that the practice management was approachable and these staff understood the recent changes and the need for them. However some staff felt that there was isolation between the different departments and that more could be done to improve communication between them.

There were regular practice meetings. Minutes were kept and there was a structured agenda. The range of meetings encompassed significant events, palliative care and weekly meetings with the community nursing teams.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements for example in the way that some aspects of the appointments system were structured.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local schemes to improve outcomes for patients in the area. For example there was a joint clinic with a charity for people with substance misuse problems, there were ultrasound and dermatology clinics run in collaboration with other providers.

The practice was a training practice and all the staff were to some degree involved in the training of future GPs. The quality of GP registrar (GPs in training) decisions was under near constant review by their trainers. The practice was subject to scrutiny by the Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. Registrars were encouraged to provide feedback

Are services well-led?

Good

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

on the quality of their placement to the Deanery and this in turn was passed to the GP practice. Therefore GPs' communication and clinical skills were regularly under review.