Long Catlis Road Surgery

Quality Report

Long Catlis Road Surgery,
Parkwood Health Centre,
Long Catlis Road,
Rainham
Kent,
ME8 9PR
Tel: 01634 233491
Website: www.longcatlisroadsurgery.nhs.uk

Date of inspection visit: 20 May 2015
Date of publication: 10/09/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Long Catlis Road Surgery on 20 May 2014. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and training was planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

.

There was one area of practice where the provider needs to make improvements.

Summary of findings

Importantly the provider should

- Review its auditing activity to help ensure its effectiveness and to more closely reflect the population it served.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice had recognised that staff might not be recognising some incidents and had undertaken training to alleviate this. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. 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 the average for other GP practices in the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient'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 had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and 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 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?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised and learned lessons from them.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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, preventing unplanned admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were very high and consistently above the national standards for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There was a mother and baby clinic each Thursday at the practice and this was advertised to that patient group.

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

Summary of findings

been identified and were met with continuity of care. The practice was proactive in offering online services, such as text message reminders, 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 practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. It had carried out annual health checks for people with a learning disability.

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). All of the people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Some clinical and administrative staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

We spoke with six patients. We received 37completed comment cards. All the patients were pleased with the quality of the care they had received from the GPs and nurses. Two patients we spoke with said it was difficult to get through on the telephone in the mornings and two comment cards reflected this. Other patients we spoke had not experienced this problem and three patients' comment cards praised the appointments system as being effective and efficient. Most patients said that they were seen at, or close to, the time of their appointment.

There was a survey of GP practices carried out on behalf of the NHS twice a year. In this survey the practice results were compared with those of other practices. . A total of 240 survey forms were sent out and there were 114 responses.

The practice's results were very positive: 80% of respondents with a preferred GP usually get to see or speak to that GP, the local (CCG) average was 59%; 84% of respondents find it easy to get through to this surgery by phone, local average 67%; 80% of respondents usually wait 15 minutes or less after their appointment time to be seen local average: 60%; also 97% found receptionists at this surgery helpful. There were no areas in the patient survey where the practice did not match or exceed local standards

.

Areas for improvement

Action the service SHOULD take to improve

- Review its auditing activity to help ensure its effectiveness and to more closely reflect the population it served.

Long Catlis Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team comprised a CQC inspector and GP specialist advisor and a practice manager specialist advisor.

Background to Long Catlis Road Surgery

Long Catlis Road Surgery is a GP practice located in the Parkwood area of Rainham Kent. It provides care for approximately 3000 patients. The practice is in an urban area.

The practice is part of a larger GP provider in the area called the Minster Medical Group. There are five partners in this group and locations within the group share some functions such as human resources, policies and governance. There are two GP partners who work regularly at Long Catlis Road Surgery and there are two regular locum GPs who work there. There are male and female GPs. There are two practice nurses, both female.

The population the practice serves is close to the national averages. There are marginally more young people (aged less than 18 years) and slightly more older people (aged more than 65 years). Income deprivation and unemployment are low being about half and one third of the national figures respectively.

The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a full training practice. It is involved in the training of doctors under the foundation year 2 scheme (FY2). This is a scheme whereby newly qualified doctors move onto a programme structure designed to give experience of managing patients in various environments including general practice.

The practice is open between 8.30am and 6pm Monday to Friday, save half day closing, at 1.30pm, on Wednesdays. Appointments are from 8.40am to 11am every day save Wednesday when the morning session ends at 11.30am. Afternoon sessions are Monday and Tuesday 4.20pm until 5.30pm, Wednesday closed, Thursday 4pm until 5.30pm and Friday 3pm until 5pm. The practice is closed at weekends. When the practice was not open during the core hours, 8am to 6.30pm cover was provided by another practice within the Minster Medical Group or by the out of hours service.

The surgery building is a purpose built health centre. The practice shares the building with other providers such as, another GP practice and community services. There are two consulting rooms, a treatment room and administrative rooms.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by Medway on Call Care (MedOCC)**.** There is information for patients on how to access the out of hours service when the practice is closed.

Why we carried out this inspection

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

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

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.

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

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 20 May 2015. During our visit we spoke with a range of staff including two partner GPs, a practice nurse, the acting practice manager, 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

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. This was a small practice and staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff. There were records of significant events. We looked at two incidents, in both cases there had been an investigation and processes had changed as a result. Both events had been discussed at staff meetings.

We reviewed safety records and two incident reports for the preceding 12 months. These showed the practice had managed incidents consistently over time and so could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we reviewed these. The practice felt that the level of reporting of significant events was too low for the size of the practice. They had undertaken training with staff and this had led to incidents being reported, such as labels becoming detached from samples which, in the past, might not have been reported. On talking with staff we confirmed that there had been significant events, which had been resolved without harm to patients, which staff had not reported because they did not know that the events ought to have been reported. Following the training staff felt more confident about what matters needed to be reported. Significant events were discussed at the practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that the GP and locum GPs were trained to the appropriate level (level three) for child protection. Nursing staff we spoke with had also been trained appropriately (level two). There was a lead GP for safeguarding of both adults and children. Staff had received training and knew how to recognise signs of abuse in older people, vulnerable adults and children and who was the lead for safeguarding within the practice. There were contact details for the local safeguarding teams available to staff and flow charts showing how to manage safeguarding issues. We talked through two reported incident that had been handled sensitively and effectively as well as being reported appropriately.

There was a process for dealing with safety alerts. These were received by the practice manager and, if relevant, forwarded to the GPs, the nurses and the dispensary manager. Staff told us of safety alerts that they had recently seen.

There was a chaperone policy, which was displayed on the waiting room noticeboard but not in the consulting rooms. Staff had been trained to act as a chaperone. Details of the offer of a chaperone and the details of the chaperone were recorded in the patient's notes.

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 were records kept that showed the refrigerators were maintained within the correct temperature range. We looked at refrigerated medicines and found that they were in date. Expired and unwanted medicines were disposed of in line with regulations.

There was a system for the management of high risk medicines, which included regular monitoring in line with national guidance. Action was taken based on the results of this monitoring by calling patients in for consultation and discussion about their medicines.

We spoke with the practice nurse and were told that vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance (the patient group directions) these had been reviewed and were in date.

Cleanliness and infection control

Patients we spoke with told us they had no concerns about cleanliness. The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with ample personal protective equipment including a range of

disposable gloves, aprons and coverings. Antibacterial gel was available in the reception area for people to use and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the building.

The building was cleaned by NHS external contractors. There were cleaning schedules and records of the actions taken if problems or poor standards of work were reported.

The practice had a lead for infection prevention control (IPC) who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. It was not always clear which staff were responsible for some aspects of infection control. This had led to some minor problems such as ensuring that each clinical room had all the correct sharps bins available and identifying who was responsible for ensuring that all the actions in any IPC audit were completed. All staff received induction training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which helped them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these to comply with the practice's infection control policy.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. Items of portable electrical equipment had been safety tested in accordance with regulations. Clinical equipment, for example weighing scales had been calibrated at the required intervals.

Staffing and recruitment

Records 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) had been completed for all staff

The practice had a recruitment policy that set out the standards it followed when recruiting all staff. There were records to show that the professional registration checks for all GPs and nurses with the Nursing and Midwifery Council (NMC) or the General Medical Council (GMC) had been completed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system for all the different staffing groups to help ensure that enough staff were on duty. There were arrangements for members of staff to cover each other's annual leave.

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. Records demonstrated that the actual staffing levels and skill mix were in line with the planned staff deployment.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors. There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. There was a lock which the staff always used, on the door to the staff reception area to prevent unauthorised access. There was a maintenance book so that staff could report faults. Health and safety information was displayed for staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. All staff had up to date training for basic life support, Emergency medicines and emergency equipment was available. There were two emergency medicines that were kept at the Minster Medical Groups other sites which were not available at the Long Catlis Road practice. We discussed this with the practice and, since the inspection, they procured these medicines and they are available. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

There was a business continuity plan to deal with a range of emergencies that might impact on the daily operation of the practice. It was up to date and was centred around using the Minster Medical Group's other sites. The practice

Good

Are services safe?

had experienced an information technology failure and the contingency plan, which involved printing and retaining schedules of appointments, had been tested and had worked.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from other sources. For example a standard tool was used for assessing depression, which was recognised by mental health professionals nationally. The practice followed local clinical commissioning group (CCG) guidelines for example in secondary referrals to dermatology and ophthalmology services. The practice also used the used CCG guidelines for the prescribing of antibiotics. The available data showed that the practice's performance for most prescribing was in the same range as similar practices.

The practice was commissioned for the new enhanced service designed to prevent unplanned admission to hospital (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Under the new service the practice identified the top two percent of the adult practice population with the most complex needs most of whom were older people. These patients had a personalised care management plan and support, tailored to the needs and preferences of the patient and their family. The practice reviewed the information from hospital admissions and used computerised tools to identify patients who were at high risk. These patients were reviewed regularly and the practice's patient record system was used to alert staff when dealing with these patients.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

There was regular monitoring to assure and improve outcomes for patients. There was some auditing. The practice had carried out an audit of atrial fibrillation (AF is a condition characterized by rapid and irregular beating of the heart) an initial audit had been carried out and a second cycle was planned to check that improvements were effective. All the patients diagnosed with AF had been reviewed by the practice in the previous year using the standard tool recommended by national guidance. This compared favourably with the national figure which was approximately 97%. The practice had started an audit of referrals to secondary care but this had not progressed beyond a first cycle. There was no audit plan and the practice accepted that a more structured approach to audits was necessary. There had been some prescribing audits carried out in cooperation with the local prescribing advisors.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice achieved high QOF results and regularly reviewed its QOF outcomes. For example 100% of patients with a mental health problem had individual care plans and all of these had had their physical health checked in the past year. For patients with hypertension (raised blood pressure) 97% had been given advice about healthy living in the last year. In the monitoring of the health of asthmatics the practice had reviewed 90% percent of those patients in the last year. These three sets of results, mental health, hypertension and asthma, compare favourably with those reported nationally at 86%, 82% and 76%. This was true for most of the other areas where QOF results were reported such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis.

There was a protocol for repeat prescribing which followed national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records. There was an overall training plan. Mandatory training such as safeguarding, basic life support and infection prevention

Good

Are services effective?

(for example, treatment is effective)

control had been completed by all staff. The areas of training that were considered to be most important for the safety of patients and staff had therefore been completed. Staff had completed fire safety training.

We noted a good skill mix among the doctors with GPs having qualifications in child health, sexual and reproductive health and surgery. One of the GPs was a GP with a Special Interest (GPwSI) in substance misuse. (A GpwSI is a formal accreditation that reflects the GP's expertise in a specific area that has been achieved through a range of activities, such as education, research and involvement with service development and management). All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice nurse was an advanced nurse practitioner (a nurse practitioner is a nurse who has completed advanced coursework and clinical education beyond that required of the generalist registered nurse) and a nurse prescriber. This allowed her to prescribe medicines within her clinical competence. The nurse practitioner saw patients aged 1 year and over (excluding pregnant women), who had new acute problems for example coughs, abdominal pains, urine infection, ear ache, and new musculoskeletal symptoms. The nurse triaged patients for medical treatment, gave telephone advice and made home visits. There was a healthcare assistant who supported practice nurses with their daily work and carried out tasks such as blood pressure measurement and new patient checks.

All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager. Staff told us of training they had attended such as handling difficult people and managing complaints.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a work stream 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. There had been no serious incidents in the previous year resulting from a breakdown in the system. All staff we spoke with understood their roles and felt the system worked well. The practice work stream was well managed.

The practice worked with other professionals such as district nurses, social services, GPs and other specialists. For example, there had been regular multidisciplinary meetings with the palliative care service. GPs attended monthly meetings of the CCG where initiatives, such as that involving surrounding practices and the community trust to develop integrated primary care pathways, to benefit patients moving from or between services, were being developed.

Information sharing

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

The practice had protocols and systems for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. Referrals were by electronic means and by letter. These were dictated or handwritten and typed up by medical secretaries.

Consent to care and treatment

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 the notice of the GP or nurse dealing with the patient.

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, care and treatment as well as how

Good

Are services effective?

(for example, treatment is effective)

that consent should be recorded. Consent was specifically recorded for any invasive procedures. Staff we spoke with understood the consent and decision-making requirements of legislation and legal guidance.

Health promotion and prevention

All new patients were given a health questionnaire and had a health check with a healthcare assistant. Those on repeat medications were referred to the appropriate nurse in the first instance and to a GP if necessary. New patients over 75 years of age were all offered an appointment with a GP. The practice also offered NHS health checks to all its patients aged 40 to 75 years. We were told of several instances where these checks had led to the early diagnosis of long term conditions such as heart conditions.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check.

During 2012 - 2013 the practice had identified that 244 patients over the age of 15 and actively offered nurse-led smoking cessation clinics to 222 of them. This placed the practice in the top 40 percent when compared with practices locally and nationally. The practice's performance for cervical smear uptake was 91%. Since 2005 the practice had consistently bettered the national performance. The practice had achieved between 84 and 96% uptake while the national performance was between 80 and 84%.

The practice had achieved particularly well in the area of child immunisation, percentages of children immunised significantly outperformed national levels. In the last year the practice achieved immunisation of 100 percent of the 12 months of age group. At 24 months it achieved 100% in all but one of the standard immunisations (where it achieved 97% and in the five year old group the practice's performance was better than that achieved nationally for each standard immunisation. There was a mother and baby clinic each Thursday at the practice and this was advertised to that patient group

The practice offered influenza vaccinations in line with current national guidance. The performance for vaccinations for patients over 65 years and for patients whose condition meant that they were at in increased risk, if they caught influenza, was better than that achieved nationally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had a confidentiality policy as well as information governance policies that guided staff and helped to ensure patients' private information was kept confidential.

Patients completed 37 comment cards to tell us what they thought about the practice. Patients thought that the care provided was good and that staff were respectful and considerate. Several comments related to the fact that patients felt there was continuity of care as they tended to see the same GP. This view was corroborated by the GP National survey where 80% percent of patients, completing the questionnaire, said that they got to speak to their preferred GP, this compared with 59% locally. Five patients mentioned the difficulty in getting through on the telephone to make appointments but this was at variance with the patient survey where 84% said that it was easy to get through on the telephone, as opposed to 67% locally.

A number of questions in the national patient survey and the friends and family test covered the care patients received in the practice. The responses to these questions were line with the national averages. For example 81% of patients felt that GPs treated them with care and concern and that figure rose to 96% when patients were asked the same question about nursing staff. Eighty six percent describe their overall experience of the practice as good.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. We saw that staff always knocked and waited for a reply before entering any the rooms. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard. The rooms were, if necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

Incoming telephone calls answered by reception staff and private conversations between patients and reception staff that took place at the reception desk could be overheard by others. However, when discussing patients' treatments staff were careful to keep confidential information private.

Reception staff had had training on the importance of patient confidentiality. There was a private room was available should a patient wish a more private area in which to discuss any issues.

There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour, this was also displayed on the practice's website.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The patients rated the practice well in these areas. Data from the national patient survey showed 76% percent of practice respondents said the GP gave them enough time, was good at explaining tests and treatment and involved them in care decisions. For nurses the same questions had a response rate of approximately 79% percent. Both these results were in line with those both locally and nationally.

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 supported the theme that GPs and nurses gave patients enough time.

The practice used the electronic care record to alert staff to patients with certain conditions. Where patients had a number of conditions staff tried to make a single, extended, appointment so that that individual's needs could be attended to in one visit. This avoided patients making repeated visits to separate clinics for each condition.

The practice had access to translation services and there were notices in the reception areas informing patents this service was available. There was a protocol for staff to follow if they needed to engage the services of an interpreter though staff said that this was rarely needed as the practice population was predominantly English speaking. There was no hearing loop for those with hearing difficulties but the configuration of the reception desk made this impracticable. We saw staff dealing sympathetically with a patient who was hard of hearing.

Good

Are services caring?

There was some confusion over the patient's understanding of the medicines that had been supplied. Staff made extra effort and obtained clarification so that the patient understood what was needed.

Patient/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. Patients we spoke with during the inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Patients we spoke with, some of whom were also carers, said that the practice was very supportive of carers and those needing care. There were notices in the patient waiting room and on the patient website which directed patients to support groups and organisations for carers as well as for patients with long-term conditions. The website was particularly comprehensive offering links and advice on social, legal, financial, personal and emotional matters. There was information about a national carers' charity with local branches.

When families had suffered bereavement GPs contacted the family by telephone to offer support or an appointment if required and to signpost the family to other services that could support them in bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered. For example the practice was located within a health centre and there were phlebotomy (taking of blood samples), physiotherapy, midwifery and other services on site.

The practice had a patient participation group (PPG). There was one annual meeting which was attended by approximately 30 to 40 patients. It was advertised well in advance, patients were e-mailed and called by telephone, and an agenda circulated. Members of the group said that they had influenced change at the practice such the way in which the morning appointments were allocated to patients. They were kept informed of changes affecting the practice. For example the practice had taken on an extra 600 patients during the last year because of the closure of a nearby practice and the impact of this had been explained. The group members we spoke with felt that an annual meeting was an effective approach to patient involvement and participation. They gave examples of how the group offered to assist with the purchase of some information technology items.

There had been a patient survey in July 2014 and there were concerns raised about the time patients spent in the waiting room before being called to see the GP or nurse. This was discussed at staff meetings and staff felt that better advertisement of the ability of patients to book double appointments, when necessary, would help to alleviate the problem. Reception staff now advised patients that double slots could be booked. There had been no follow up survey but the national patient survey showed that 72% of patients were seen after waiting between 5 and 15 minutes whereas the local figures showed that only 50% were seen in that time frame with many waiting much longer.

Tackling inequity and promoting equality

Patients with disabilities could access the practice. There was a ramp leading to the front door so that patients in wheel chairs and mothers with prams could use it. The waiting area easily accommodated wheelchair users. There were toilets for the use of disabled patients and baby changing facilities. There was a quiet room where mothers could feed their babies.

There was a register of patients who had illnesses which made them particularly vulnerable, for example a learning disability, dementia or end of life care. When staff accessed the notes of such patients a message was displayed on the computer screen to inform the staff member of the diagnosis. Thus they were better able to manage their interaction with that person by taking into account any difficulties that the patient might have, such as difficulties in communication, memory or understanding.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The website could be translated into a wide range of languages using a simple translate page button on the webpage itself.

Primary medical services were provided Monday to Friday from 8.30am to 6.30pm, the practice was not closed for lunch. There were no extended hours for general surgeries. The Minster Medical Group was trialling extended hours at another site. It was awaiting the results of the trial before deciding what form of extended hours, if any, to use at this site.

There were pre-bookable appointments, up to several weeks in advance, and appointments available on the day. Patients were booked into the next available GP appointment. There were telephone consultations available, on the day, for patients where this was appropriate. Older patients requiring urgent care were seen on that day either as an emergency appointment or in a home visit if the person was housebound. Where children required urgent appointments, they were seen as soon as possible and, in any event, on the day.

Longer appointments were available for patients who needed them and for those with long-term conditions. There was a range of standard longer appointments. For example patients with a single long-term condition received a 10 minute appointment with a GP and those with more than one problem could book double appointments. Appointments with the practice nurse were

Good

Are services responsive to people's needs?

(for example, to feedback?)

for 10 minutes with some exceptions, for example where patients had more complex or compounding problems. Patients could receive a reminder about appointments using mobile telephone text messaging.

Most patients we spoke with were satisfied with the appointments system. These patients and the comment cards showed that patients felt that they could see a doctor on the same day if they needed to. In surveys 82% of patients, who responded, said it was easy to get through to the practice on the telephone; the average in the area was 69%. In the same survey 97% felt that the reception staff were helpful in making appointments, this compared with 85% in the locality. As regards the convenience of the appointment 91% of patients found their appointment convenient and this was in line with results locally. The practice had recently started some on line booking of appointments

Listening and learning from concerns and complaints

There was a complaints policy which included the 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. There were leaflets in the practice and material on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However, all felt that if they had to make a complaint they would be listened to and the matter acted upon.

Complaints were received both verbally and in writing. Records showed how complaints had been handled and how the patients had been informed about the outcome. There had been learning from complaints. For example, complaints about how the appointments were allocated for the morning sessions at the practice had led to a more accountable process where patient received a numbered slot that reflected their priority. Lessons learned from complaints were discussed amongst GPs and staff to reduce the chances of similar events happening again.

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. 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 complaints 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 their philosophy was to put patients' needs at the centre of everything they do. This was published on the practice website. The practice's aim was to offer their patients a wide range of high-quality services targeted to best meet their needs, to deliver high quality care and promote good health and wellbeing for patients. The staff we spoke understood the practice's aims. Staff told us that they felt well led and described a practice that was open and transparent.

Governance arrangements

Clinical governance was covered in a range of activity and was linked to the clinical governance of the parent group, Minster Medical Group. There were policies and procedures that governed activity and guided staff. These were available to staff on the desktop on any computer within the practice. We looked at some of these including information governance, workflow policies and protocols, chaperoning, infection control, incident reporting, access to medical records, recruitment and induction and others. There was evidence that staff had read the policies. The policies we looked at were in date and had dates assigned for their review.

The practice had a planned governance system with GPs and managers designated as leads in different areas such as safeguarding, medicines management, prescribing, complaints and health and safety. There were leads for other responsibilities such as a business and finance lead.

There were two clinical governance meetings annually. A range of issues was discussed which included prescribing practice, Quality and Outcomes Framework performance, patient safety and serious incidents. The practice learned from incidents, for example measures to improve the processes on recording patient allergies, on sending out referrals for scans and tests and completing records for patients with depression had been discussed and implemented. The meeting was also used to inform GP and nurses about national and local clinical commissioning group changes as for example the efforts to reduce the amount of certain antibiotics being prescribed. Specific patients, and possible alternative treatments, were discussed. There was regular e-mail traffic between the GPs which aimed to keep them up to date with, for example, best prescribing practise or new local clinical pathways.

There were regular administrative staff meetings. Relevant items from the minutes of the clinical governance meetings were discussed with the administrative staff. Lessons learned from complaints were discussed as well as the changes that had come about from the learning. Staff contribute to the practice for example, they felt that there had been an improvement in the appointment system and that the telephone consultation process was effective and that patients were happy to use it where it was appropriate.

The practice had carried out some clinical audits. There had been an audit on the patient experience with the fitting of coils and implants this had identified that there could be improvement to the counselling and information provided to patients so that they were more aware of the level of discomfort they might expect so that they could identify when the discomfit they were experience was beyond the norm. There were various audits driven by the practice's performance against QOF targets such as audits of the monitoring of patients on high risk medicines. The audits were reactive, usually in response to an incident or patient safety alert. There was no overall audit plan and audits were not planned to address the needs of the more common population groups within the practice.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through a variety of means, including complaints, patients' surveys, the patient participation group and the friends and family test (an NHS wide initiative that provides an opportunity for patients to offer feedback on the services that provide their care and treatment).There was an action plan resulting from this feedback. The main area for action was; to make more double appointments available when necessary and to ensure that patients knew about this facility. Reception staff gave advice to patients if they were unsure whether they needed an extended (double) appointment. However reception staff were careful not to give clinical advice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included a personal development plan. Staff were very positive about the practice commitment to development and spoke about the wide range of training that had been made available to them. One practice within the Minster

Are services well-led?

Good

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

Medical Group had been inspected by the Care Quality Commission within the previous two months. The inspectors had highlighted some areas, such as auditing and dealing with bereaved patients, where they though the practice might be able to make improvements. At this inspection the management had already begun to address those issues at this practice.

The practice was accredited for the training of foundation year 2 (FY2) doctors. These are qualified doctors who are seeking a meaningful experience in general practice. The practice was subject to scrutiny by the Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. FY2 doctors were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. GPs' communication and clinical skills were therefore regularly under review.