St Anne's Group Practice

Inspection report

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Herne Bay
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

Overall summary

This practice is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at St Anne's Group Practice on 22 May 2018. This inspection was carried out 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured care and treatment was delivered according to evidence-based guidelines.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- There was a clear leadership structure and staff felt supported by management.
- Patients we spoke with and some comment cards indicated that patients sometimes found it difficult to get through to the practice on the telephone and to access routine GP appointments. The practice was aware of this and were looking at establishing a reception hub to deal with phone calls in a different way. Urgent appointments were available on the same day.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- The practice worked collaboratively with a health and social care organisation that worked across mental health, learning disability, substance misuse, primary care, the criminal justice system and employment.
- The practice had employed a pharmacist and Herne Bay Town had also employed a pharmacist, between them they were doing polypharmacy medication reviews as well as post discharge medicines reconciliation and though not specifically targeting the elderly, inevitably however, because of their demographics, this was often focussed on elderly patients.
- The practice and community pharmacists were working with the other Herne Bay practices and starting to develop a one stop shop for Diabetes. This would be for the whole town, however currently it was just for patients at St Anne's Group Practice. This was run by a GP, a practice nurse and a pharmacist. The plan was to relocate to the Queen Victoria Hospital and that both practices in Herne Bay would cover on a rota basis.
- There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met these needs and promoted equality. This included patients who were in vulnerable circumstances or who had complex needs. For example, the practice funded a GP led substance misuse service in partnership with a national health and social care provider that provided patients with access to weekly clinics.
- The practice had been proactively involved with the Herne Bay Care Home pilot scheme, which was part of the East Kent Frailty Service being developed across the whole health Economy. The project which was funded for three months, targeted care homes which were then visited by a community geriatrician and a GP who would arrange with the home to review patients and produce high quality anticipatory care plans for patients. The second phase of the project which was about to be implemented was the reactive element, whereby the care home would have a single number to ring, instead of defaulting to 999 which would enable the care home to get immediate clinical advice or a visit if necessary to try and reduce further hospital admissions. The practice continued to support this scheme without any funding.
- There was seven days a week access to minor surgery at St Anne's Group Practice including cataract surgery, dermatology and carpal tunnel surgery. The practice had performed approximately 220 per year which was 35% of East Kent procedures. Patients attended the

Overall summary

Beltinge location minor surgery unit from all East Kent CCG's (clinical commissioning groups). The success rate was last measured up to January 2017 and the success rate measured by patient self-rating questionnaires stood at 88%.

- The practice had had an increase in the number of MARAC (multi-agency risk assessment conference) referrals to the point where they are one of the highest areas in East Kent.

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

Population group ratings

Older people	**Outstanding** ☆
People with long-term conditions	**Outstanding** ☆
Families, children and young people	**Outstanding** ☆
Working age people (including those recently retired and students)	**Outstanding** ☆
People whose circumstances may make them vulnerable	**Outstanding** ☆
People experiencing poor mental health (including people with dementia)	**Outstanding** ☆

Our inspection team

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

Background to St Anne's Group Practice

St Anne's Group practice delivers services from two sites, St Anne's Surgery and Beltinge Surgery. Both are located in Herne Bay, Kent. At St Anne's Surgery all patient areas are on the ground floor and are accessible to patients with mobility issues, as well as parents with children and babies. There is one consulting room on the first floor at Beltinge Surgery which is primarily used by the counselling service. A lift is available to help make this service accessible for all patients.

There are approximately 14400 patients on the practice list. The practice has more patients aged 85 years and over (practice average 4%, local average 3% and national average 2%).

Information published by Public Health England, rates the level of deprivation within the practice population group as six on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice holds General Medical Service contract and consists of nine GP partners (six male and three female) and one salaried GP. St Anne's Group Practice is a training practice so, alongside their clinical roles, the GPs provide training and mentorship for trainee GPs. There are currently two GP registrars training at the practice. The practice has employed a paramedic (male). There are seven practice nurses (female), a lead nurse (female) one pharmacist (female), two healthcare assistants (female), a phlebotomist (phlebotomists take blood samples). Alongside their clinical roles the nurses provide training and mentorship for student nurses.

The GPs, nurses and pharmacist are supported by a practice manager and a team of administration and reception staff. A wide range of services and clinics is offered by the practice including: asthma, diabetes and antenatal clinics. There is a seven day a week minor surgery unit at the Beltinge branch where patients across Kent can receive services such as cataract surgery.

The practice is open Monday to Friday from 8am to 8pm. Morning appointments are from 8.40am to 11.30am, afternoon appointments are from 2.30pm to 5.30pm and evening appointments are from 6.30pm to 7.30pm.

An out of hours service is provided by NHS 111, outside of the practices opening hours. There is information available to patients on how to access this at the practice, in the practice information leaflet and on the website.

Services are delivered from:

161 Station Road, Herne Bay, Kent, CT6 5NF and

269 Reculver Road, Beltinge, CT6 6SR.

We visited both sites during the inspection.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.
- Notices in the practice advised patients that chaperones were available if required. Only nurses acted as chaperones, they had been trained to undertake this role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure facilities and equipment were safe and in good working order. Staff carried out actions to manage risks associated with legionella in the premises (legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, there was no evidence that the unused shower in the staff toilets was being flushed on a regular basis. The practice told us that the shower was going to be removed by the end of the year, and that in the interim, they had arranged with the external cleaning company to flush the shower on a daily basis. They had also arranged for a legionella risk assessment to be carried out to ensure actions were appropriate.
- Arrangements for managing waste and clinical specimens kept people safe

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- The practice had 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 enough staff were on duty. In response to patient feedback regarding telephone access, staff had received training to work across roles and teams. For example, during peak times or staff absences, members of staff from the administration team would move to reception to provide support.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Reception staff had access to policies in relation to patient medical emergencies. Clinicians knew how to identify and manage patients with severe infections including sepsis.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.
- There was a documented approach to managing test results and we saw results were dealt with in a timely way.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.

Good

Are services safe?

- There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG medicines optimisation teams, to help ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Temperature checks for refrigerators used to store medicines and vaccines had been carried out and records of those checks were made.
- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. We saw evidence the practice had reduced antibiotic prescribing in the last 12 months from over to under the national average.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to most safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

Please refer to the Evidence Tables for further information

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. Although this data is related to the previous provider, systems and staffing have remained largely the same.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- All clinical staff had easy and immediate access to both written and online best practice guidance.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were lower than the target percentage of 90% or above. We saw current unvalidated data from the practice that showed uptake rates for the vaccines given were higher than the target percentage of 90% or above.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses

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Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice's uptake for cervical screening was 74%, which was in line with the 72% for the national average.
- The practice's uptake for breast and bowel cancer screening was above the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice provided a telephone travel consultation service, which was followed by an appointment if required.

Good

Are services effective?

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Patient with a learning disability had access to a specialist nurse who reviewed them and their care. The next step was to develop this to enable home visits for care reviews with the specialist nurse and a GP.
- The Practice regularly worked with other healthcare professionals, social services in case management of vulnerable people who were identified at weekly multi-disciplinary team meetings.

People experiencing poor mental health (including people with dementia):

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice reviewed the care of patients diagnosed with dementia in a face to face meeting every year.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 97%, which was above the CCG and national average of 90%. In 2016-2017 the exception reporting for mental health care plan reviews was 36.67%. We were told that a high percentage (27 patients) were excluded as informed dissent, 19 of which were exception reported after no response to three attempts to recall by either letter, telephone call or failed appointment attendance. The other eight informed dissents were actual patient declines. After looking at the exception audit in detail, the practice told us that there were several patients where the diagnosis was reactive confusion and one with ADHD and anxiety, so patients were unsuitable for mental health care planning. Two patients were in-patients on psychiatric wards towards the end of the financial year when the practice were chasing any patients that were still outstanding for their review. The practice recognised that providing a more specialised approach to mental health would hopefully see better attendance by offering patients more availability and consistency and they employed a Mental Health Nurse.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice used information about care and treatment to make improvements. For example, the practice had reviewed the care and treatment given to patients who had been fitted with an intrauterine device (IUD/IUS or coil, is a small, often T-shaped birth control device). They identified areas to improve the six weeks coil check.

There was good evidence of improvement in prescribing practice. Staff had audited practice prescribing of antibiotics against best practice guidelines. Where appropriate, clinicians took part in local and national improvement initiatives. The practice had entered into a quality contract with the clinical commissioning group (CCG) which covered many areas of local service delivery. As part of this contract, they regularly reviewed and reported on areas of patient care and treatment, for example those patients with atrial fibrillation and hypertension.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. One of the practice reception staff had trained as a phlebotomist.

Good

Are services effective?

- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Conversations between receptionists and patients could be overheard in the patient waiting areas. The receptionists were aware of patient confidentiality and we saw that they took account of this in their dealings with patients. There was a private area if patients wished to discuss sensitive issues or appeared distressed.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given) and staff had trained in this standard.

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice did not have many patient information leaflets available in the waiting rooms. However, information on services, how to complain and share feedback was shown on a television in the waiting room. Staff were able to print off material for patients when needed, for example in the event of a new diagnosis.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice and all of the population groups as outstanding for providing responsive services.

- The practice worked collaboratively with a health and social care organisation that worked across mental health, learning disability, substance misuse, primary care, the criminal justice system and employment.
- There was seven days a week access to minor surgery at St Anne's Group Practice including cataract surgery, dermatology and carpal tunnel surgery. The practice had performed approximately 220 per year which is 35% of East Kent procedures
- The practice had employed a pharmacist and Herne Bay Town had also employed a pharmacist, between them they were doing polypharmacy medication reviews as well as post discharge medicines reconciliation.
- The practice and community pharmacists were working with the other Herne Bay practices and starting to develop a one stop shop for Diabetes. This would be for the whole town, however currently it was just for patients at St Anne's Group Practice.
- The practice funded a GP led substance misuse service in partnership with a national health and social care provider that provided patients with access to weekly clinics.
- The practice had had an increase in the number of MARAC (multi-agency risk assessment conference) referrals to the point where they were one of the highest areas in East Kent.

Responding to and meeting people's needs

The services were flexible, provided choice and ensured continuity of care. The involvement of other organisations and the local community was integral to how services were planned and ensured that services met patient's needs. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for vulnerable people with multiple and complex needs.

- The practice understood the needs of its population and tailored services in response to those needs.
- The percentage of respondents to the GP patient survey who answered positively to the question, "Did you have confidence and trust in the GP you saw or spoke to was 100% which was above the CCG average of 97%, and national average of 96%.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- The practice had been proactively involved with the Herne Bay Care Home Pilot, which was commissioned through the East Kent Frailty Steering Group (and based on evidence from the Care Home Vanguards nationwide). The pilot was to provide high quality anticipatory care plans for residents in six Herne Bay care homes to review the sustainability and feasibility to roll out across the wider East Kent Health economy. The project, funded for three months, targeted six care homes reported to be higher than average for unplanned admissions or A&E attendances, and were then visited by a clinical team (community geriatrician and a GP or paramedic/advanced nurse practitioner) to complete the anticipatory care plans for all residents. The practice was currently continuing this scheme without further funding. However, following the learning from the pilot a service specification was being drafted for consideration by the East Kent Frailty Steering Group to extend this pilot and roll out across East Kent. As part of the East Kent frailty Steering Group initiative an Advice and Guidance Line was also introduced. The care homes had a single number (care home support line) to ring, instead of defaulting to 999 enabling the care home to get immediate clinical advice or a visit if necessary to try and reduce further hospital admissions. The Local Referral Unit (LRU) call centre (open 8am-8pm seven days a week) took these calls and transferred them to a clinician in the Rapid Response team or in the case of the pilot homes to the GP practice professional's phone. After the initial launch the LRU were receiving on average five calls a week across East Kent with often calls from the same home (but not the same resident).

Are services responsive to people's needs?

The volume of calls was not expected to increase beyond 15 a week and outcomes data was currently unavailable, however, the service was regularly monitored through listening to the calls and weekly conference calls with the Clinical Commissioning Group (CCG).

- The practice employed a pharmacist and Herne Bay Town also employed a pharmacist, between them they were doing polypharmacy medication reviews as well as post discharge medicines reconciliation and though not specifically targeting the elderly inevitably, because of the demographics, this was often focussed on elderly patients.
- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- Patients aged over 75 were offered 10 minute appointments with a GP as standard. Extended appointments would be available upon request from the patient or GP.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and paramedic also accommodated home visits for those who had difficulties getting to the practice.
- The practice hosted weekly multidisciplinary team meetings, where doctors across the town met together with the Community Trust, Mental Health Teams, Age UK, Canterbury City Council and Social Care to maximise medical and non-medical support for elderly patients.

People with long-term conditions:

- The practice pharmacist and community pharmacists were working with the other Herne Bay practices and starting to develop a one stop shop for Diabetes, using joint resources from across the town. This would be for the whole town, however currently it was just for patients at St Anne's Group Practice. This was run by a GP, a practice nurse and a pharmacist. The plan was to relocate to the Queen Victoria Hospital and that both practices in Herne Bay would cover on a rota basis. This project was at such an early stage that the practice could not provide any meaningful data, other than Herne Bay had a higher prevalence of Diabetics across the town. Currently, the practice had started Pharmacist run clinics at St Anne's to review patients on a high number of medications, alongside their existing Diabetic Nurse clinics.
- The practice held regular meetings with the local integrated neighbourhood team to discuss and manage the needs of patients with complex medical issues.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. The practice had reviewed the way that these reviews were carried out and enabled multiple conditions to be reviewed at one appointment. Consultation times were flexible to meet each patient's specific needs.

Families, children and young people:

- The practice had introduced a 'baby card' system to support new parents and help direct them to local services.
- We found 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- Patients had access to GPs outside normal working hours as the practice was open until 8pm Monday to Friday, and GP appointments were available on Saturdays and Sundays operating out of the Queen Victoria Hospital in Herne Bay. This is predominantly staffed by doctors from St Anne's and William Street Surgeries. Alongside this, the practice also proactively supported the Minor Injury Unit at the Queen Victoria Hospital.
- There was seven days a week access to minor surgery at St Anne's Group Practice including cataract surgery, dermatology and carpal tunnel surgery. The practice had performed approximately 220 per year which is 35% of East Kent procedures. Patients attended the Beltinge location minor surgery unit from all East Kent CCG's. The success rate was last measured up to January 2017 and the success rate measured by patient self-rating questionnaires stood at 88%.

Are services responsive to people's needs?

- The practice offered NHS health checks to patients aged between 40 and 74 years of age.

People whose circumstances make them vulnerable:

- The practice had had an increase in the number of MARAC (multi-agency risk assessment conference, a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist, police, children's social services, health and other relevant agencies all sit around the same table. They talked about the victim, the family and perpetrator, and shared information. The meeting is confidential), referrals to the point where they are one of the highest areas in East Kent.
- The practice funded a GP led substance misuse service in partnership with a national health and social care provider that provided patients with access to weekly clinics.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia):

- The practice employed a Mental Health Nurse who specialised in comprehensive mental health care reviews as well as specialised learning disability reviews, she was also planning on developing this further by offering dementia reviews as well as screening. For example, there had been improved attendance for learning disability reviews. In 2016-2017 there had been 11 (15%) of checks undertaken, however, figures provided by the practice showed that in 2017-2018 33 (46%) had been undertaken. The practice recognised that providing a more specialised approach to mental health would hopefully see better attendance by offering patients more availability and consistency. The practice told us that this seemed to have been the case; since employing a Mental Health Nurse they had seen exception rates drop considerably, particularly in those who did not respond to recalls. The practice's exception rate for MH care plan reviews 2017-18 was 19.79%, they had 11 patients exception reported as informed dissent, four of which were after three or more failed attempts to recall and seven actual informed declines. They hoped to see further improvement with attendance rates as the Mental Health Nurse became more established and was able to build relationships with patients
- The practice proactively identified those patients who were showing signs of dementia and referred them to secondary care when appropriate.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients experiencing undue anxiety were given the option to wait in a separate room or in their car if they preferred until it was time to see the clinician.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- The percentage of respondents to the GP patient survey who gave a positive answer to "Generally, how easy is it to get through to someone at your GP surgery on the phone?" was 35% compared to the CCG average of 78% and national average of 71%. In response they had reviewed telephone access and had a plan to extend appointment bookings to six weeks in advance. The practice manager told us that they had upgraded their telephone system so that patients were made aware of what number they were in the queue when calling, and also request a call back.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Staff met with GPs weekly to ensure that there were enough appointments available in the near future. GPs supplied extra appointments or employed a locum GP when necessary, for example during the winter months when there was increased patient demand.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from

Are services responsive to people's needs?

individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. All patient complaints were discussed with staff so that they could reflect on their practice. We saw that a few complaints that the practice had received allowed for this reflection and did not give rise to any learning needs. In all cases, patients were reassured that their treatment had been appropriate and further advice had been given.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The business plan set out goals and objectives for the practice. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. This was being done jointly with other local practices in order to map out services and provide them in a co-ordinated, streamlined way.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Good

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were sound arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information...