Dr Robert Stewart

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Robert Stewart (also known as The Hawkinge and Elham Valley Practice) on 11 March 2015. Overall the practice is rated as good.

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

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, with the exception of those relating to recruitment checks.
- 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 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.

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. 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.

The practice offered a chaperone option where a member of staff would be available to accompany patients during intimate examinations at their request (or at the instigation of the clinician involved) and looks after a baby or child while their mother was being examined by a GP or nurse. Reception staff confirmed that they had received chaperone training.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence 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 to help patients understand the services available was easy to understand. Staff were observed treating patients with kindness and respect, whilst maintaining their 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. The

Summary of findings

practice was one of eight practices in the South Kent Coast Clinical Commissioning Group (CCG) (one of 20 CCGs selected nationally, out of 250 bids) to be awarded the Prime Minister's Challenge Fund to enable them to establish a GP service based at the local NHS hospital, allowing all the eight local practices in the Folkestone area to host primary care services, seven days a week, from 8am to 8pm and an urgent home visit service outside of core practice hours (8am-6.30pm). Appointments were booked via the practice's reception or NHS 111.

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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their 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 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 and events.

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 provider was rated as good for caring for older people. The provider was rated as requires improvement for safety. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The provider was rated as good for caring for 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. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The provider was rated as good for caring for families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high 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, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. A walk-in and wait contraception/HRT clinic was held on a Tuesday afternoon and chlamydia testing “grab boxes” at both surgeries were available for young people to collect testing packs without the need to speak to a clinician. The practice also offered pre-booked appointments with their practice nurse for contraception advice for young people.

Summary of findings

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The provider was rated as good for caring for people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good for caring for people experiencing poor mental health (including people with dementia). The practice had a dementia register of 98 people experiencing poor mental health and 90 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. It carried out advanced care planning for patients with dementia. There was a dedicated trained GP who saw patients who had mental health issues and those on the mental health register were reviewed regularly. The practice undertook dementia screening, for patients over the age of 50 with a cardiovascular condition identified by a GP as being at risk of developing dementia. Screening was also offered to patients outside this group who were expressing a concern.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and a mental health helpline. It had a system to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

All of the six patients we spoke with on the day of our inspection were complimentary about the care and treatment they received. We reviewed the seven patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. The comments were positive about the care and treatment people received. Patients told us they were

treated with dignity and respect and involved in making decisions about their treatment options. Some patients told us they experienced problems getting through to the practice on the telephone to make an appointment. Most patients however, told us the appointment system was easy to use and met their needs.

The practice sought feedback from staff and patients, which it acted on. The practice had previously had a virtual patient participation group (PPG) who they worked with to address concerns from patients. This is a group which had been set up in response to patients that had said they would like to be involved in a patient group but were unable to attend meetings. As a member of the virtual patient participation group they would be sent emails asking for their opinion on a range of topics. This has now progressed into an actual Patient Participation Group (PPG) and the first meeting was scheduled to be held on 19 March 2015.The practice had gathered feedback from patients through the national patient survey, NHS Choices, compliments and complaints. The results from the national patient survey showed that 95% of patients said that their overall experience of the practice was good or very good and that 80% of patients would recommend the practice to someone new to the area.

Dr Robert Stewart

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The lead inspector was accompanied by a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Robert Stewart

Dr Robert Stewart (Also known as The Hawkinge and Elham Valley Practice) is situated in a converted house and located in the residential area of Hawkinge. The building has benefitted from subsequent extensions and refurbishments which have improved space and access. Wheelchair access to the building is through the front door. The inspection was undertaken at the Hawkinge practice. We did not visit the practice branch at Elham Valley.

A team of two GP partners, two salaried GPs, two locum GPs (all male), a nurse specialist/clinical services manager, two prescribing nurse practitioners, two assistant practitioners, two practice nurses, a nurse specialist, a practice manager, a performance manager, receptionists, medical secretaries and administrative staff provide care and treatment for approximately 9,220 patients.

The nursing team provide a wide range of care in the treatment room. The nurse specialist/clinical services manager specialises in the management and treatment of patients who have heart disease or have had a heart attack, stroke/mini-stroke, atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), peripheral vascular disease, management and treatment of hypertensive disease and heart disease prevention, family planning, contraceptive advice and women's health. The prescribing nurse practitioners are available daily and can be seen for a wide range of acute illnesses such as colds and flu, sore throats, infections, diarrhoea and vomiting. One of the prescribing nurse practitioners also specialises in respiratory problems such as chronic obstructive pulmonary disease (COPD) and asthma. The practice nurses undertake blood pressure monitoring, child and adult vaccinations, cervical smears, dressings, ECGs (a test which records the rhythm and electrical activity of a patients heart), ear syringing and other general nursing duties. The assistant practitioners support the practice nurses with their daily work and carry out tasks such as phlebotomy (drawing blood), blood pressure monitoring, weight management and new patient checks. They may act as a chaperone when a patient or doctor requests one. The phlebotomy clinics are held Wednesday morning at Elham Valley and Thursday and Friday mornings at Hawkinge.

Appointments are available from 8.30am to 6.30 pm Monday to Friday and 8.30am to 8pm on a Thursday. Saturday mornings were from 8.30am to 12.30pm. The practice provides an out-of-hours service to their own patients and appointments are booked via the practice's reception or NHS 111 when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 March 2015. During our visit we spoke with three GPs, the practice manager, two nurse practitioners, one practice nurse, one assistant practitioner, two receptionists, practice administrator, performance manager and six patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the wrong patient had been put on the triage list but the right telephone number had been given. The GP rang the number but entered the data on the wrong patient record. We looked at minutes of weekly clinical meetings and saw that the incident had been discussed and all staff reminded of the care needed when booking appointments and undertaking consultations. The lesson learned was that when booking appointments staff needed to double check the patient's date of birth and first line of their address.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of 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. Records were kept of significant events that had occurred during the last year and these were made available to us.

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

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. Once completed these were sent to the practice manager (or in their absence these were sent to the performance manager) who showed us the system they used to ensure these were managed and monitored. We tracked five significant events and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, we saw that one patient had been given the wrong specimen request form, the patient returned with form as they had realised the mistake. The GP was advised and appropriate action was taken to resolve the issue. Following the incident, systems had been changed to prevent this from happening again.

National patient safety alerts were disseminated by the practice manager (or if on annual leave diverted to performance manager) to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the weekly clinical meetings and nurse meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example, all GPs and nursing staff had level three training for children and level two training for adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs and nurses as leads in safeguarding vulnerable adults and children. Records confirmed they had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. We saw that weekly meetings were held with the safeguarding lead and senior GP to discuss the practice's safeguarding. There was a system to highlight vulnerable patients on the practice's

electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans that were on the local safeguarding team protection register. We saw that the safeguarding register was reviewed by a lead GP and nurse every three months to ensure that it was up to date. We saw evidence that the practice had raised safeguarding vulnerable adult alerts for patients who were living in nearby care homes. We saw that these had been discussed at a clinical meeting and with the managers at the care homes and reported to the CCG. Records evidenced appropriate contact with external agencies such as social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Reception staff had not had appropriate Disclosure and Barring Service (DBS) checks (previously known as Criminal Records Bureau (CRB). The practice had undertaken a risk assessment of the process and the chaperone policy stated that reception staff had not had a DBS check since they were not the first person a clinician would call and they were never alone with a patient.

We saw that all the doctors and nurses had received the appropriate Disclosure and Barring Service (DBS) checks (previously known as Criminal Records Bureau (CRB) to help ensure that people who used the service were protected.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the procedures detailed in the medicines policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice medicines management meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of analgesics (painkillers), inhaled corticosteroid (inhalers for asthma) and antidepressant prescribing within the practice.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and had received appropriate training to administer vaccines. Two members of the nursing staff were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Patients requiring repeat prescriptions were able to request them either in writing, on line or could put the repeat prescription paper request in the post box in reception. Repeat prescriptions could also be sent electronically to a nominated chemist of the patient's choice enabling them to collect a prescription when it was convenient to them. The practice did not routinely take prescription requests over the telephone.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for the last two years and that any improvements

identified for action were completed on time. We saw evidence to support the risk assessment in infection control of the premises in 2013 and ongoing risk assessments and clinical waste audits carried out in May 2014. The most recent risk assessment identified that locum staff were more likely to put inappropriate waste in the sharps bins. For example, paper, cotton wool balls or dispose of sharps. As a result of the audit, the practice had labelled all the bins with laminated prompt cards with exactly what should be put in them, to encourage correct disposal of waste by all staff. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled 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 would use these to comply with the practice's infection control policy. Clinical staff we spoke with told us that they used sanitizing gel between seeing each patient and hand washing to avoid contamination. We found consistent information about the use of personal protective equipment especially with the GP who undertook minor operations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury of this nature.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records for 2014 that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was September 2014. A schedule of testing was in use. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers (an apparatus for measuring the volume of air inspired and expired by the lungs), blood pressure measuring devices and the fridge thermometer. Emergency equipment such as a defibrillator (electronic devices that apply an electric shock to restore the rhythm of an irregular heart) was available for use in a medical emergency. We saw that the equipment was checked monthly to ensure it was in working order and fit for purpose.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had two locum GPs and their documents had been validated.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative whose

Good

Are services safe?

duty it was to bring to the notice of the employers and employees any new hazards as they arose. We saw that a fire risk assessment has been carried out in 2013. The practice also had a health and safety policy.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at clinical meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). A named GP was the designated resuscitation lead. Minutes of a clinical team meeting evidenced that the resuscitation lead had demonstrated to all staff how to operate the new community defibrillator located on the outside of the building. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice had detailed protocols and guidelines for non-clinical and clinical staff when dealing a patient medical emergency via either telephone or in person.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (anaphylaxis is a sudden allergic reaction) and hypoglycaemia (abnormal low level of blood sugar). There were processes to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A disaster handling and business continuity plan was available and detailed how to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the telephone company if the system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this for the incapacity of a GP that occurred during the course of business and the mitigating actions that had been put in place to manage this.

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 local commissioners. We saw minutes of clinical team meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, management of depression in pregnancy guidelines and referrals to other healthcare professionals. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with neuropathic pain (pain that comes from problems with signals from the nerves), anxiety disorder, partial epilepsy and secondarily generalized partial epilepsy, which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. For example, housebound and long term condition patients.

All GPs we spoke with used national standards for the referral of patients. For example patients with suspected cancers to ensure they were seen within two weeks. We saw that two week referrals were discussed at the weekly GP meetings. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The practice used the Referral Assessment Service (RAS) to refer patients to other services through choose and book system (a system that enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) and we saw an example of when this had been carried out.

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. The practice actively promoted and supported the ethos and the requirements of the Equality Act 2010 and had an equal opportunities/anti-discrimination (service provision) policy. The practice provided the same treatment and services (including the ability to register with the practice) to any visitor irrespective of age, sex, marital status, pregnancy, race, ethnicity, disability, sexual orientation, medical condition, religion or belief.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. 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). For example, we saw an audit regarding the prescribing of analgesics (pain killers). Following the audit, the GPs carried out

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Are services effective?

(for example, treatment is effective)

medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients and had achieved a score of 850.95 out of 900 (94.6%). For example, 77.1% of patients with asthma had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) dementia, depression, hypertension, rheumatoid arthritis. 68.7% of all patients on the dementia register received an annual review which included a medication review. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. Benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, child immunisation, antibiotic prescribing and hospital referral rates.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix with three GPs and the nurse specialist/clinical manager having additional diplomas in sexual and reproductive healthcare. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the assistant practitioner had been supported to undertake a foundation degree in health and social care.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of immunisation and vaccines, cervical screening, ear irrigation and menopause and hormone replacement therapy (HRT). Those with extended roles seeing patients with long-term conditions such as anaemia management, stroke prevention, coronary heart disease prevention and cardiac rehabilitation were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 GPs used "Share My Care" to share information with the 111 and ambulance service. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for

Good

Are services effective?

(for example, treatment is effective)

the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service to provide care for over 75s and patients who may be at risk of unplanned admissions and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had employed a full-time nurse practitioner care co-ordinator who was the first point of contact for their housebound patients and older population.

The practice held monthly multidisciplinary team and palliative care meetings to discuss the needs of complex patients. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 92.5% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Since October 2014, as part of the Prime Ministers Challenge fund and the over 75s plan, the practice had benefited from the services of a visiting paramedic practitioner who undertakes visits on behalf of the practice for any of their patients. Since October 152 of home visits had been to patients over the age of 75. We witnessed a handover between the GP and paramedic before going out on a visit to an elderly patient.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS 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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, where a patient could not give consent for a cervical smear test. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept a register of 55 patients with a learning disability and records showed that 47 care plans had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All GPs and nursing staff demonstrated a clear

Good

Are services effective?

(for example, treatment is effective)

understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25. A walk-in and wait contraception/HRT clinic was held on a Tuesday afternoon and chlamydia testing "grab boxes" at both surgeries were available for young people to collect testing packs without the need to speak to a clinician. The practice also offered pre-booked appointments with their practice nurse for contraception advice for young people.

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 47 out of 55 had received an annual physical health check. Practice records showed 100% had received a check up in the last 12 months. The practice had also identified the smoking status of 81% of patients between the ages of 14-19 known to have asthma, and actively referred them to the local pharmacy who ran smoking cessation clinics for these patients. 1,011 patients who were current smokers, 99% had been given support to stop smoking compared to the national average of 90%. Records showed that 58 patients had stopped smoking between April 2014 and March 2015. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice had a dementia register of 98 people experiencing poor mental health and 90 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. It carried out advanced care planning for patients with dementia. There was a dedicated trained GP who saw patients who had mental health issues and those on the mental health register were reviewed regularly. The practice undertook dementia screening, for patients over the age of 50 with a cardiovascular condition identified by a GP as being at risk of developing dementia. Screening was also offered to patients outside this group who were expressing a concern.

The practice's performance for cervical smear uptake was 87%, which was better than the national target of 80%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named receptionist responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG. For example, for breast screening 1,057 patients over the last three years were eligible to have the screening, 80.6% (860) patients had the screening compared to the CCG average of 79% and for bowel screening 68.7% between July and September 2014 undertook the screening compared the CCG average of 59.5%. A similar mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, a survey of patients undertaken by the practice's virtual patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The practice had previously had a virtual patient participation group (PPG) who they worked with to address concerns from patients. This is a group which had been set up in response to patients that had said they would like to be involved in a patient group but were unable to attend meetings. As a member of the virtual patient participation group they would be sent emails asking for their opinion on a range of topics. This has now progressed into an actual Patient Participation Group (PPG) and the first meeting was scheduled to be held on 19 March 2015.

The practice had gathered feedback from patients through the national patient survey, NHS Choices, compliments and complaints. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the data from the national patient survey showed that 95% of patients said that their overall experience of the practice was good or very good compared to the local CCG average of 86% and that 80% of patients would recommend the practice to someone new to the area. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 95% of practice respondents saying the GP was good at listening to them and 96% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received seven completed cards and they were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice had a telephone hub in a room which was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a warning letter on the practice electronic system stating the practice's zero tolerance for abusive behaviour that would be sent to a patient who had been reported as being abusive. If the abusive behaviour applied to a member of staff, the practice manager would meet with the member of staff and discuss their unacceptable behaviour.

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 and generally rated the practice well in these areas. For example, data from the national patient survey showed 84% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were above average compared to the local CCG area.

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

Good

Are services caring?

they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. Patients we spoke with on the day said they had received help to access support services to help them manage their treatment and care when it had been needed. The comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had, in the past, had a virtual patient reference group who had given them help, support and guidance in providing services for their patients. This has now progressed into an actual Patient Participation Group (PPG) and the first meeting was scheduled to be held on 19 March 2015.

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients with a learning disability, those with poor mental health or dementia and carers. The practice had access to online and telephone translation services. There was access to a hearing loop for people who had hearing impairment and, if required, the practice contacted a local service for signing for patients with a hearing problem.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had benefitted from subsequent extensions and refurbishments improving space, access, and facilities to meet the needs of patients with disabilities. For example, there was wheelchair access to the front of the building and disabled parking. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice website had been designed to meet the requirements of the Disability Discrimination Act and made every effort to ensure the site's contents were accessible to those with special needs, including those with visual, hearing, cognitive and motor impairments.

Access to the service

Appointments were available from 8.30am to 6.30pm Monday to Friday and 8.30am to 8pm on a Thursday. Saturday mornings were from 8.30am to 12.30pm. This supported working age patients and children and young people to access appointments outside of normal working hours.

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. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice was one of eight practices in the South Kent Coast Clinical Commissioning Group (CCG) (one of 20 CCGs selected nationally, out of 250 bids) to be awarded the Prime Minister's Challenge Fund to enable them to establish a GP service based at the local NHS hospital, allowing all the eight local practices in the Folkestone area to host primary care services, seven days a week, from 8am to 8pm and an urgent home visit service outside of core practice hours (8am-6.30pm).

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice had employed a full-time nurse practitioner care co-ordinator who was the first point of contact for the housebound and older patients. This has enabled the practice to provide care plans for their older patients which were reviewed on a three monthly basis. As a result of this increased clinical staffing the practice had been able to visit all 59 of their housebound patients and perform long term condition reviews, where appropriate, and/or create a care plan. Home visits were made to a 90 bed nursing/care

Good

Are services responsive to people's needs?

(for example, to feedback?)

home and the practice provided a weekly GP visit and a Friday afternoon visiting service by the nurse practitioner care co-ordinator, to support the home and their families and avoid weekend hospital admissions. All clinics for patients with long term conditions were given 30 minute appointments. Patients with complex needs would receive an appointment for 20-30 minutes.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment and was seen by a GP on the same day. The practice was able to text appointment reminders to patients who pre-book appointments up to one month in advance.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. Information on how to complain was displayed in the waiting room and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 14 complaints received in the last 12 months and found they had all been reviewed and analysed in a timely way and that there was openness and transparency in dealing with the compliant. For example, we saw that a patient had complained regarding an online prescription request being rejected without advising the patient. Records showed the complaint had been analysed and the lesson learned was that when a GP rejects an online prescription there was no facility to ask the reception to speak to the patient and that a blood test was required prior to issuing the medicine. This was explained to the patient and they were happy with the explanation.

We saw evidence that the practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes or trends within the complaints had been identified. However, lessons learned from individual complaints had been acted on. The practice manager showed us an audit of the complaints and staff told us they were informed of the results of this audit through management and clinical team meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan 2013-2018. The practice vision was to provide the most effective quality patient centred care within the resources available using technology and skill mix within the neighbourhood of integrated organisations. The practice was based on six key values care, compassion, commitment, competence, courage and communication.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice away day held on 27 April 2013 and saw that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 22 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 22 policies and procedures had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

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

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, we looked at an audit of patients with atrial fibrillation (AF) (a heart condition that causes an irregular and often abnormally fast heart rate) undertaken in December 2014. On completion of the audit, recommendations were made that included the patient's pulse should be checked at every clinical contact to increase AF detection. The practice had recently undertaken an audit of patients experiencing poor mental health comparing hospital and secondary care data with coding on their medical system to ensure that all patient information and medication was up to date and that patients were receiving the correct care and follow up treatment.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as loss of domestic services or information technology; Control of Substances Hazardous to Health (COSHH); fire safety and buildings maintenance. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. A full risk assessment had been carried out prior to the extension and refurbishment of the premises in 2013 and we saw that all the work had been completed for example, floors had been replaced throughout with non-slip easy to clean flooring.

Leadership, openness and transparency

We saw from minutes that clinical meetings were held regularly, at least weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held annually.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example whistleblowing, age discrimination, equality and diversity which were in place to support staff. We were

Are services well-led?

Good

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

shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through national patient surveys, comment cards and complaints received. We looked at the results of the annual GP patient survey and 82% of patients agreed Saturday morning appointments would be useful. We saw as a result of this the practice had introduced Saturday morning appointments. The practice was also planning their own in-house survey as part of the Productive General Practice programme. They were hoping that they would receive assistance from their newly formed PPG in order for this to be undertaken.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, we saw that in February 2015 a significant event had been discussed where the wrong patient had been booked in error into a GPs telephone triage appointments, which meant the wrong patient was advised re changes to their medicine. The incident was investigated and analysed and the process of the booking and the appointment system discussed. The lesson learned was the need to positively identify every patient at every contact and this was reiterated to all staff.