Cobtree Medical Practice

Quality Report

Cobtree Medical Practice
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 Cobtree Medical Practice on 1 June 2017. Overall the practice is rated as outstanding.

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

- There was an open culture in which all safety concerns raised by staff and patients were highly valued as integral to learning and improvement. The level and quality of incident reporting showed included assessments of harm and near misses, which ensures a comprehensive picture of safety. All opportunities for learning from internal and external incidents were maximised. The practice shared learning from safety incidents with other nearby practices on a regular basis.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example through having a child themed a "fun day" which had doubled the child take up of influenza vaccinations.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG). For example the practice had held a public meeting about a proposed merger of practices with the support of the PPG.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Feedback from patients about their care was positive and was consistently significantly better than local and national feedback. There was continuity of care, in the most recent GP national survey, 95% patients saw their GP of choice compared to national average of 59%.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this

Summary of findings

vision had been produced with stakeholders and was regularly reviewed and discussed with staff. All staff were involved in developing the vision and values for proposed merged practice.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice including:

- GPs gave a designated mobile contact telephone number to patients who were dying at home and were contactable in the event of a crisis out of surgery hours and at weekends. The same facility was available to the clinical staff the local nursing home for advice on avoiding admission to hospital or end of life care.
- Data showed that patients rated the practice significantly higher, for the caring and the responsive aspects of its services, than all the local and national averages.
- The practice had proactively recruited patients to the patient participation group so that it was truly representative of the practice demographic.
- The practice had mounted an initiative to increase the take up of influenza vaccinations for children aged two, three and four which had had a regional impact.
- The practice had identified patients likely to be at risk of acute kidney injury,had sent them informative leaflets and monitored their welfare.

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.

- From the examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to help prevent the same thing happening again.
- A proactive approach to anticipating and managing risks to people who use services is
- embedded and is recognised as the responsibility of all staff.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- There was a record of "near miss" events at the dispensary. These were analysed and reported on annually.
- The GPs met with other local GPs monthly they discussed recent safety alerts, best practice and near miss safety events across all the practices so that opportunities to learn from external safety events were identified.

Are services effective?

Good

The practice is rated as good for providing effective services.

- There were systems to help ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example the recent establishment of a register of those who may be at risk for acute kidney injury.
- Data showed that the practice was performing highly when compared to practices nationally. The practice scored 100% of QOF points across a range of common long term conditions

Summary of findings

- The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice. For example an initiative to increase the take up of influenza vaccinations for children aged two, three and four which had had a regional impact.
- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services.

Data from the national GP patient survey showed patients rated the practice higher than others for all aspects of care. For example the practice scored 100% in range of questions related to caring for patients and was above local and national averages in all the other related questions. Feedback from patients about their care and treatment was consistently positive.

We observed a strong patient-centred culture:

- Approximately a third of the comments cards we received specifically mentioned the caring attitude of staff. We observed a strong patient-centred culture. Receptionists knew the patients well. Patients told us there was a homely feel to the practice.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example reception staff told us they would ring vulnerable patients or those with young children if their appointments were running late so that they would not spend excessive time in the waiting room.
- We found positive examples to demonstrate how patient's choices and preferences were valued and acted on. For example we saw that very elderly patients discussed the benefits of taking medicines, designed to prolong life, against the side effects of these medicines. So their decision was informed by their personal circumstances.
- Views of external stakeholders, such as staff at a local care home, were very positive and aligned with our findings.
- GPs gave a designated mobile contact telephone number to patients who were dying at home and were contactable in the event of a crisis out of surgery hours and at weekends. The same facility was available to the clinical staff the local nursing home for advice on avoiding admission to hospital or end of life care.

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Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning services that met patients' needs. For example the practice conferred with secondary care consultants using a web based application so that more patients could be treated at the practice rather than at hospital outpatients departments.
- There were innovative approaches to providing integrated patient-centred care. The practice organised a child themed day to encourage children to have an influenza vaccination. The initiative had had a regional impact.
- The individual needs and preferences of people with a life-limiting condition, including patients with a condition other than cancer and patients living with dementia, were central to their care and treatment. Care delivered was flexible and provided choice.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG). For example there was a traveller representative on the PPG and the arrangements for appointments for the travelling community were changed to reflect both the literacy difficulties and cultural preference of that community.
- Patients could access appointments and services in a way and at a time that suits them. In the most recent independent poll of patients the practice results scored extremely highly for continuity of care and access to services.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led.

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. The practice carried out succession planning. This

had led to a recent change in the practice structure and to the planning of a merger between practices. Staff were involved in defining the practice values and vision for a proposed merged practice.

- High standards were promoted and owned by all practice staff and teams worked together across all roles. There was a very low staff turnover with a well-established team where staff worked across roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us that they felt empowered to make suggestions and recommendations for the practice.
- The practice gathered feedback from patients, and it had a very engaged patient participation group. The practice had proactively recruited patients so the group was representative of the practice demographic, including school age patients, carers, the disabled, those with a mental health condition and the traveller community. The group had identified and developed a number of improvements to practice.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The factors that led to the practice being rated as outstanding over applied to all the population groups, therefore the practice is rated as outstanding for the care of older patients.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Two staff members visited the housebound elderly to administer influenza vaccinations.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example repeat prescriptions for elderly patients, who had difficulty in attending the practice, were accepted over the telephone.
- The practice offered proactive, personalised care to meet the needs of older patients. It looked after 25 high dependency beds at a local nursing home. Staff there had the GPs telephone number and were able to contact the GP at weekends or out of hours to discuss end of life care or measures to prevent admission to hospital where this was appropriate. All the patients at the home had detailed care plans with an emphasis on avoiding unplanned admission to hospital. There was a nominated GP who held a weekly ward round at the care home.
- Palliative care patients, most of whom fell into this population group, and their families had a designated GPs mobile telephone number and were able to contact the GP at weekends or out of hours to discuss end of life care.

Summary of findings

- There was an older patient who represented this population group on the patient participation group.

People with long term conditions

Outstanding

The factors that led to the practice being rated as outstanding over applied to all the population groups, therefore the practice is rated as outstanding for the care of patients with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice's QOF performance for 2015/2016 in diabetes related indicators was similar to the CCG and national averages. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 72% compared with the national and local average of 77%.
- The practice scored 100% of QOF points for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, depression, dementia, heart failure, hypertension and mental health. In all these cases the practice results were higher than the local and national averages.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs. GPs identified patients at risk of hospital admission as a priority. The practice had lower than average admission to accident and emergency (A&E) across patients with long term conditions. For example it had had no admissions to A&E for diabetic emergency and had the lowest figure of any practice in the locality.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- There was a patient with a long-term condition who represented this population group on the patient participation group.

Families, children and young people

Outstanding

The factors that led to the practice being rated as outstanding over applied to all the population groups, therefore the practice is rated as outstanding for the care of families, children and young people.

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- From examples we reviewed 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. When a child did not attend a hospital appointment this triggered an alert to the lead for child safeguarding so that appropriate action could be taken.
- Immunisation rates were 90% or more for all standard childhood immunisations. This was despite the fact that there was a substantial proportion of children from the traveller community who are historically difficult to reach with these services.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice served the needs of boarders at a nearby school, there was a drop in-clinic weekly and access to emergency contraception, for patients registered at the practice and others who were not.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- There was an adolescent patient who represented this population group on the patient participation group.

Working age people (including those recently retired and students)

Outstanding

The factors that led to the practice being rated as outstanding over applied to all the population groups, therefore the practice is rated as outstanding for the care of working age people (including those recently retired and students).

- The needs of these populations 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.

Summary of findings

- The practice provided health checks for new patients and NHS health checks for patients aged 40–74.The practice was the highest achieving for this service across the clinical commissioning group (CCG) with 101%.
- The practice had developed a “one stop shop” for diabetic patients that reduced the number of appointments those patients needed to attend. This impacted particularly on working age patients.
- The evening clinic was staffed by a nurse and GP enabling working age patients to consult with the nurse and go directly to the GP, if necessary, rather than returning for a further appointment.

People whose circumstances may make them vulnerable

Outstanding ☆

The factors that led to the practice being rated as outstanding over applied to all the population groups, therefore the practice is rated as outstanding for the care of patients 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 all patients with a learning disability and these patients were offered longer appointments.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- There was a nominated GP who held a weekly ward round at the local care home.
- There was a representative from the traveller community on the patient participation group, who had been very active in

Summary of findings

improving understanding of the needs of that community. The practice responded to these needs by being readily available to see patients without an appointment usually at the beginning or end of sessions.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The factors that led to the practice being rated as outstanding over applied to all the population groups, therefore the practice is rated as outstanding for the care of patients experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients with dementia. Eighty eight percent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average. All the staff at the practice were “dementia friends”, so had learned more about the condition and how to help patients and their families manage the condition.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Performance for mental health related indicators was similar to the CCG and national averages. For example The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have an agreed care plan during the preceding 12 months was 94% compared with the CCG average of 92% and the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could 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.
- There was a patient with a long term mental health condition who represented this population group on the patient participation group.

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What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing better than local and national averages. Two hundred and seven survey forms were distributed and 114 were returned. This represented 5% of the practice's patient list.

- 98% described their overall experience of the practice as good compared to the CCG average of 88% and the national average of 85%.
- 97% of patients described their experience of making an appointment as good compared with the CCG average of 78% and the national average of 73%.
- 96% said they would recommend the practice to someone new to the area compared to the CCG average of 82% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards which were all positive about the standard of care received. Twenty two cards mentioned how caring staff were, 12 cards commented on the listening skills of staff and 13 cards described the service as outstanding or used a similar term.

We spoke with six patients during the inspection. All the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Outstanding practice

We saw several areas of outstanding practice including:

- GPs gave a designated mobile contact telephone number to patients who were dying at home and were contactable in the event of a crisis out of surgery hours and at weekends. The same facility was available to the clinical staff the local nursing home for advice on avoiding admission to hospital or end of life care.
- Data showed that patients rated the practice significantly higher, for the caring and the responsive aspects of its services, than all the local and national averages.
- The practice had proactively recruited patients to the patient participation group so that it was truly representative of the practice demographic.
- The practice had mounted an initiative to increase the take up of influenza vaccinations for children aged two, three and four which had had a regional impact.
- The practice had identified patients likely to be at risk of acute kidney injury, had sent them informative leaflets and monitored their welfare

Cobtree Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector**.** The team included a GP specialist adviser.

Background to Cobtree Medical Practice

The Cobtree Medical Practice is a GP practice located in the village of Sutton Valance Kent. It provides care for approximately 2500 patients. The practice is in a rural area.

There are two GP partners and a salaried GP, one male and two female. There are two practice nurses, both female, one being a regular locum nurse.

The age of the population the practice serves is close to the national averages. There are marginally more young people (aged less than 18 years) and slightly more older people (aged over 64 years). Income deprivation and unemployment are low being about half and one sixth of the national figures respectively. About five per cent of the practice's patients come from the traveller community.

The practice has a general medical services contract with NHS England for delivering primary care services to local communities. The practice offers a full range of primary medical services and is able to dispense medicines to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy premises. The practice is not a training practice. The practice hosted student nurse placements as part of the Primary Care Education Network.

The practice is open between 8am and 6.30pm Monday to Friday. There is an evening surgery until 7.45pm on Tuesdays. Appointments are from 9am to 1pm and 2.15pm until 5.30pm.

The surgery building is a converted detached house with consulting and treatment rooms on the ground floor and administrative rooms upstairs.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by Integrated Care 24**.** There is information, on the practice building and website, for patients on how to access the out of hours service when the practice is closed.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 1 June 2017. During our visit we:

- Spoke with a range of staff including GPs, dispensary staff, management staff and reception staff. We poke with patients who used the service.

Detailed findings

- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We looked in detail at ten reported events. We found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice had developed a "could do better" form for incidents which were not sufficiently serious so as to be classed as significant events but from which lessons might be learned. The practice carried out a thorough analysis of the significant events which were discussed every other month as well as at an annual review meeting.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example we saw an incident that involved a significant dispensing error. Actions arising from the investigation included the updating of standard operating procedures, a review of dispensing staff training and a system to double check all dispensed items. We saw that the patient in this case received both verbal and written apologies, the appropriate support and was told about the outcome of the practice's investigation.
- There was a record of "near miss" events at the dispensary. These were mistakes that were corrected before any medication was taken by the patient. In addition to taking any immediate corrective action the near misses were analysed and reported on annually. There had been 16 such incidents in the previous year. The practice had dispensed approximately 36,000 items. The report identified the most common threats for example, medicines in the same colour boxes, patients with similar names and the use of certain generic medicines. The dispensing staff told us they discussed the report and this helped them to be more vigilant to the most common causes of error.
- The practice also considered positive events, for example an expected death that had been well managed. The patient passed away at their place of choice. The practice reviewed the case. It was felt that regular discussion at multi-disciplinary meetings had helped all concerned to manage the outcome successfully and this point was shared in practice meetings.
- The practice partners met with other local GPs monthly (called the journal club) they discussed recent published research, safety alerts and best practice. We saw that they discussed a recent "near miss" concerning a patient presenting with vague symptoms including tiredness and feeling stressed. The patient had a serious condition. The club discussed the associated symptoms, the relevant professional guidance and the importance of early blood tests in such cases.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff we spoke with showed that they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nursing staff were trained to level two or level three as appropriate. Administrative staff were also trained to level two though the mandatory level required was level one. The practice felt that the administrative staff needed the higher level of training because of their frequent interaction with the public. When a child did not attend a hospital appointment this triggered an alert to the lead for child safeguarding so that appropriate action could be taken.

Good

Are services safe?

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the 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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We saw that the premises were clean and tidy. There were cleaning schedules and these were monitored.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before medicines were given to patients and there was a reliable process to ensure this occurred. The practice was a system to identify when patients, who were prescribed medicines which required particular safety checks, had not had those checks. These patients were then followed up to help to ensure that their medicines were being safely administered.
- Repeat prescriptions for elderly patients, who had difficulty in attending the practice, were accepted over the telephone. The practice acknowledged that this was a risk but had audited the arrangements and found no mistakes.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to 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.
- There were nurses who had qualified as independent prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the GPs for this extended role. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Nuring staff had regular clinical supervision.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and their competence was checked regularly by the lead GP for the dispensary. The lead GP had completed a relevant diploma qualification. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of regular review of these procedures in response to incidents or changes to guidance in addition to annual review. The practice was accredited by the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.

We reviewed four staff files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

Good

Are services safe?

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota to ensure enough staff were on duty to meet the needs of patients. We saw that as a result of a significant event the rota had been reviewed and changes made to help ensure that patients' needs were met.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The practice used the guidelines, for example by using ambulatory blood pressure monitoring for the diagnosis of patients where hypertension (raised blood pressure) was suspected. The practice utilised local guidelines such as the Clinical Commissioning Group (CCG) guidance in respect of impaired glucose tolerance.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 72% compared with the national and local average of 77%
- Performance for mental health related indicators was similar to the CCG and national averages. For example The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have an agreed care plan during the preceding 12 months was 94% compared with the CCG average of 92% and the national average of 89%.
- The practice achieved 100% of QOF points for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, depression, dementia, heart failure, hypertension and mental health. In all these cases the practice results were higher than the local and national averages.
- exception rates for clinical domains were similar to or lower than national averages (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

There was evidence of quality improvement including clinical audit:

- There had been 10 clinical audits commenced in the last two years, five of these were completed audits where the improvements were made and monitored. These included audits involving medicines such as injectable contraception, the treatment of heart conditions, use of novel oral anticoagulants and cancer diagnosis.
- An audit of the practice's cancer diagnosis, showed very positive results. None of the practice's patients had had cancer first diagnosed in hospital. The National Cancer Intelligence Network study indicates that the diagnosis of cancer in hospitals ranges from 31% (over 70s) to 24% (all ages). Emergency cancer admissions per 100 patients on the practice's disease register was 0.16 as opposed to 7.4 nationally.
- An audit of patients diagnosed with atrial fibrillation, a heart condition that causes an irregular and often abnormally fast heart rate, identified that 94% were treated in accordance with the NICE guidelines. Three patients had decided, in consultation with their GP, not to take the treatment because of their other infirmities and general frailty. For one patient the treatment was not appropriate.
- There had been five administrative audits focused on safety issues such as infection prevention control and telephone repeat prescribing for elderly patients. The practice developed action plans from them and these had led to improvements in services.
- The practice partners met with other local GPs monthly (called the journal club) they discussed recent NICE guidance, published research and cases with learning points. We saw that two of the subjects discussed, the

consumption of processed meat and the impact of the age of the treating physician on the patient's outcome were directly concerned with improving outcomes for patients.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- There was role-specific training and updating for relevant staff such as refresher training for the practice nurse in the management of diabetes and one of the GPs had under taken training in the management of difficult diabetic cases.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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.
- We saw that the practice shared relevant information with other services a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that 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. We saw that where the end of life care was delivered effectively the practice considered what factors had been most influential in achieving the outcome and shared these with staff and with other practices.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- The process for seeking consent was monitored through patient records audits. For example, specific consent forms for surgical procedures were used and scanned onto the patient's record.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and directed them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring

Good

Are services effective?

(for example, treatment is effective)

advice on their diet, smoking and alcohol cessation. There was a proactive approach to disease prevention. For example the practice had identified patients with impaired glucose tolerance (pre diabetic patients) and offered support to mitigate the onset of the disease. These patients were offered advice and referral to social supports such as local healthy walking and cycling networks. They were offered a review annually. The support networks were prominently displayed on the practice's noticeboards.

- NHS England has recognised that Acute Kidney Injury (AKI) is an emerging global healthcare issue. Patients taking certain medicines or those with certain pre-existing conditions are more at risk. The practice carried out a search to identify patients likely to be at risk of AKI. It sent all those patients an explanatory letter, accompanied by advice on what to do in the event that the patient became unwell. The practice established a register, within the clinical system, so that all staff could identify a relevant patient and give appropriate advice, or in the case of reception staff direct the patient to a clinician.
- The practice has a large boarding school within its catchment area and frequently attends to deal with sporting injuries. Both GPs have been trained on, and introduced to the school, the latest guidelines for teenagers suffering concussion. As this recommends longer periods of rest it the GPs have managed challenges from both coaches and parents, until everyone involved in the change had been educated in its benefits.

The practice's uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 83% and the national average of 81%. There were systems to help ensure results were received for all samples sent for testing and the practice followed up women who were referred as a result of abnormal results.

Standard childhood immunisations for the practice were over 90% for all two and five year olds, despite there being a substantial traveller community who, evidence suggests, are difficult to reach with these services. When children missed an immunisation the practice telephoned the family to follow up on the non- attendance.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. The practice had been successful in this and the rates were higher than the national averages. For example the percentage of female patients (between 50 and 70 years of age) screened for breast cancer within six months of the invitation was 82% compared with the national average of 73%. The percentage of patients (between 60 and 69 years of age) screened for bowel cancer within six months of the invitation was 62% compared with the national of 56%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. There were data for the number of health checks carried out. The practice was the highest achieving in this area across the CCG with 101% (83 out of a target of 82).

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed there was a private room where they could discuss their needs.
- Patients could be treated by a clinician of the same sex.
- Reception staff told us they would ring vulnerable patients or those with young children if their appointments were running late so that they would not spend excessive time in the waiting room.

All of the 39 Care Quality Commission comment cards we received were positive about the practice, 22 out of the 39 used the words care or caring when talking about the staff. A third of the patients used the term outstanding or similar such as exceptional to describe the practice as a whole. A number of the cards mentioned the strong personal relationships that patients had with staff and included that that support had helped them through difficult periods in their life.

We spoke with eight patients including five members of the patient participation group (PPG). They told us they thought care provided exceeded their expectations. They mentioned the reception staffs' empathy and sensitivity, the availability of GPs and nurses appointments and the fact that elderly and infirm patients could still reorder their medicines over the telephone.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was markedly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 100% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 98% say the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 89% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%
- 100% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 100% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 91%.
- 100% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 92% found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. We spoke with the manager and head nurse of a care home where the practice had responsibility for 25 high dependency beds. They felt the service provided was exceptional. There was a nominated GP who held a weekly ward round. Palliative care patients and their families, as well as the care home staff, were able to contact the GP directly on a designated mobile telephone. The staff gave several examples where they had contacted the GP, out of hours or at weekends and the GP's attendance, or advice, had prevented a patient being admitted to hospital when this was not necessary and their wish was to die at the home.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and 14 comment cards out of 39 highlighted listening skills of the staff. We also saw that care plans were

Are services caring?

personalised. We saw examples where the GPs had guided patients in their decision making. For example, in an atrial fibrillation audit where older, frail patients had made an active decision not take a certain medication.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were significantly above the local and national averages. For example:

- 98% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 86%.
- 99% say the last GP they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 99% say the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (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.

Patient and carer support to cope emotionally with care and treatment

There were patient information leaflets and notices in the waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. There was a "carer's corner" in part of the waiting room. This provided details of support services, such as access to respite care, and local services such as the local voluntary car service. This service, which the practice encouraged and supported provided transport for patients in the rural community to help them access services including the practice. Some patients who might otherwise have had to be seen at home were able to come to the practice. This, the practice believed, contributed to the low home visiting rate which, given the time needed to reach the rural areas of the practice, made more GP time available for appointments. We spoke with patients who appreciated this service not simply because it helped them the come to the practice but because it helped to reduce a sense of isolation.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 53 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

The practice has a small number of palliative care patients. Their individual care was discussed monthly at a multi-disciplinary meeting. We saw several anonymised cases where patients, who wished to die at home, had been supported to do so. These had been written up and presented as significant events so as to share best practice. GPs gave a designated mobile telephone number to patients who were dying at home and we were told that this was appreciated.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. 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. There were thank you cards from the families of deceased patients thanking the practice for the support it had provided, in helping their relatives to die at their place of choice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Tuesday until 7.45pm for working patients who could not attend during normal opening hours. This was a combined clinic where patients could see the nurse, for preliminary checks if necessary, then move on the GP appointment. This reduced the need for some patients to make a further appointment.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Two staff members visited the housebound elderly to administer influenza vaccinations.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and on-going conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS.
- There were accessible facilities, which included a hearing loop and translation services.
- The practice had regular antenatal clinics and a practice midwife, these services were valued by patients. The services had been moved elsewhere because of resource issues. The practice negotiated their return through timely and articulate protest.
- About five per cent of the practice population came from the traveller community. That community had a representative on the Practice Participation Group (PPG). Through involving that person the practice had learned of the issues facing this group, for example from both literacy difficulty and cultural preference, in making pre-booked appointments. The practice made itself readily available to patients from that community by seeing them at short, or no, notice, generally at the beginning or end of the sessions.
- There is a large, mainly boarding, school within the practice boundaries. To provide for this group there was a weekly drop in clinic at the school medical centre. Older children were able to consult the practice independently. The reception staff always provided an appointment for pupils who said they needed an emergency appointment. The staff did not ask for a reason, this was to help ensure that pupils who might need emergency contraception were not discouraged from asking for it.
- The practice used a web based system to confer directly with secondary care specialists. This allowed more patients to be quickly and successfully treated by their GPs. The practice increased its use of this system by 260% during the last year. This was the second highest increase in the Maidstone area and, roughly calculated, represents 312 patients treated, initially, closer to their homes.
- An audit of influenza vaccination in the two, three and four year old age group identified that in 2015/16 24% of patients had received the vaccination. The practice sought to improve this, the target being 75%. The practice mounted an initiative, detailed under the "well led" section which had doubled the uptake to 50%.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours surgeries were offered on Tuesdays until 7.45pm. In addition to pre-bookable appointments, up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment exceptionally exceeded local and national averages.

- 93% were satisfied with the surgery's opening hours compared to the clinical commissioning group (CCG) average the national average of 76%.
- 100% found it easy to get through to the practice by phone compared with the CCG average of 76% and the national average of 73%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 95% were able to get an appointment to see or speak with someone the last time they tried compared with the CCG average of 88% and the national average of 85%.
- 100% said the last appointment they got was convenient compared with the CCG average of 94% and the national average of 92%.
- 97% described their experience of making an appointment as good compared with the CCG average of 76% and the national average of 73%.
- 95% patients said they saw their GP of choice, providing continuity of care, compared to the CCG average of 73% and national average of 59%:
- 87% patients feel they don't normally have to wait too long compared to the CCG average of 59% and national average of 58%.

The patient comment cards supported these findings and many cards mentioned the ease of obtaining appointments.

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.
- 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. For example there were notices in the waiting room and information on the practice website.

There had been no complaints in the last two years. Therefore we looked at the last two complaints received. We found that they had been handled in accordance with the practice's policy. The practice found that one complaint was substantiated and, in addition, treated it as a significant event. The patient was kept informed of the practice's investigation, verbally and in writing. A sincere and complete apology was offered in a timely fashion. The patient elected to remain on the practice's list.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, there had been changes to training, supervision and policies as a result of the first complaint.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice's mission, vision and values were set out in a statement of purpose. All the staff we spoke with were aware of the vision and what it meant for them. The mission statement included working with patients, the local community and partners to achieve the best outcomes for patients.

- There were a number of plans to monitor performance against the vision including an overarching development plan for the practice, action plans resulting from audits and patient surveys. Appraisals and individuals' development plans were linked to the practice development plan through identified areas such as training, dispensing and end of life care.
- There was a planned approach to succession planning. The practice had already moved from being a sole practitioner to being a partnership. This practice recognised that major housing developments in the area (an increase in the population of about 8000), and the strategy set out in the NHS forward view called for a review of GP services. As a result a merger was planned between this GP practice and an adjacent practice. The practice approached this systematically. There was a whole day meeting, away from practices. The agenda included an assessment of strengths and weakness, consideration of what type of practice the leaders wanted to develop and an action plan to monitor progress. There were meetings with staff from both practices to develop the vision and values for the new practice. There were meetings with the practice participation group (PPG) who proposed a public meeting, an idea the practice embraced. The practice had anticipated a few dozen attendees, however several hundred patients attended. The practice took several proposals from the meeting including having a single point of contact for public concerns. Other external agencies such as the clinical commissioning group (CCG), NHS England and parish and local councils have been involved throughout the process. The merger is planned for completion by April 2018.

Governance arrangements

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

- There were practice specific policies that were available to all staff. There was evidence that the policies had been read by staff. We looked at some of these including recruitment, chaperoning, safeguarding, bereavement and complaints they were in date and reviewed when necessary.
- There was no "senior" partner as such. Leadership in the practice fell equally to both partners and the practice manager, who was the registered manager. There were however clear leadership roles for named members of staff. For example, there was a lead nurse for infection control, a GP with responsibility for safeguarding and a lead for performance against the quality and outcomes framework (QOF) and other outcome measures. There was a comprehensive understanding of the performance of the practice.

There was regular review of the practice performance against a wide range of data:

- NHS England data (GP outcomes).
- QOF.
- Local Clinical Commissioning Group (CCG) data.
- Eclipse data (this is a real time one-line tool for bench marking in long term conditions).
- Medicines optimisation scheme (MOS).
- Referrals data, including Kinesis (a web-based software system that directly links GPs to hospital specialists for rapid access to expert advice).
- Audits.
- Significant events and/or complaints.

We looked at a range of reports resulting from the reviews. In each area the practice had noted the positive outcomes for patients and acted in areas which had been identified for improvement. For example:

- A "one stop shop" for diabetics, particularly those of working age. Retinal screening and blood tests were done on the same day with a telephone follow up for the results. This reduced (a possible) four appointments to one.
- The practice use of Eclipse data directly led to the identification of two cases of an untreated disease which might otherwise not have been identified. It led to the practice changing prescribing for painkillers from a higher risk to a lower risk medicine. The practice's commitment to the positive use of Eclipse data had been commented on by the CCG.

Are services well-led?

Outstanding ☆

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

- The MOS had resulted in an audit that evidenced that patients on particular (non-generic) medicines used for erectile dysfunction were receiving medicines that were safe for them.
- Referrals data showed that there was an improvement in patient choice through the use of "Choose and Book" (this a national electronic referral service which gives patients a choice of place, date and time for their appointment in a hospital or clinic). Kinesis allows GPs to confer directly with secondary care specialists allowing more patients to be quickly and successfully treated in the community by their GPs. The practice increased its use of Kinesis by 260% during the last year. This was the second highest increase in the Maidstone area. It represents 312 patients who did not need, at least initially, to attend an outpatients hospital clinic.
- The practice was accredited by the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. The DSQS provided an addition layer of governance in respect of practice's dispensing medicines.
- An audit of influenza vaccination in the two, three and four year old age group identified that in 2015/16 24% had received the vaccination. The practice sought to improve this, the target being 75%. The practice involved the staff and patient participation group in a creative session. The session thought that children might be attracted by a "fun day" and it was decided to hold a "superheroes and princesses" themed day. All the families were invited to attend in costume. The staff administering vaccines were also dressed in costume. The PPG provided refreshments and children's entertainment. The direct benefit was that the influenza vaccination take up in the target group increased to 50%. It was enjoyed by the children and universally praised by the parents. The event created regional coverage as a local television crew attended. The practice has received enquiries from other practices considering similar events. There is direct evidence that the event raised awareness and anecdotal evidence, from NHS England, that it may have increased the take up of the vaccination across the region.

Leadership, openness and transparency

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The partners and the practice manager were visible and it was clear that there was an open culture within the practice. Staff had the opportunity to and were happy to raise issues at team meetings. Staff told us that the GPs and management were approachable and took the time to listen.

The practice was aware of and complied with the requirements of the Duty of Candour. There had been no recent incidents that fell within the parameters of the requirement. We saw the report of an incident that acknowledged that, had the incident happened a few months later, it would have been subject to a Duty of Candour. The practice therefore treated it as such. The partners encouraged a culture of openness and honesty. The same safety incident evidenced that:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- There were regular practice meetings. Minutes were kept and there was a structured agenda. The range of meetings encompassed full staff meetings, significant events, palliative care and weekly meetings with the community nursing teams. We saw from minutes that all staff regularly contributed to how the practice developed. Staff told us of occasions when they had made suggestions at staff meetings such as changes to working practices. The changes had been accepted or, where this was not possible, staff were told why.
- There were practice team building days or social events, paid for by the practice, approximately six times a year. Staff told us that this helped to break down barriers and made it easier to speak freely, particularly about sensitive issues. Staff said they felt respected, valued and supported, particularly by the partners in the practice. Staff were very involved in the planned merger particularly in the development of the common values and vision for the new practice.

Are services well-led?

Outstanding ☆

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

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

The practice encouraged and valued feedback from patients. Patients were asked to provide feedback through the practice's website, through the patient participation group (PPG) and through in house and other surveys such as the Improving Practice Questionnaire.

- There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. The practice had examined the patient demographic and proactively recruited PPG members to represent this. There was a member of the travelling community, a disabled individual, a carer, a patient with a mental health condition and a patient of school age. From minutes we saw the PPG was chaired with professional governance. There had been advantages for the patients from the diversity of the PPG membership. For example a relatively high number of children from the travelling community, often difficult to reach, had received the standard immunisations. Other initiatives, developed and paid for by, the PPG were the "carer's corner" in the waiting room, the installation of a wall mounted magazine rack to help elderly patients and those with a back problem and the installation of a hearing loop.
- The NHS Friends and Family test, complaints and compliments received
- There had been patient surveys sponsored by the practice, but conducted independently, in 2012, 2014 and 2015. These were in addition to the National Patient Survey and all had shown high levels of satisfaction with the practice. Action plans had been developed from the results of the surveys. Improvements that had flowed from this included the development of new technologies such as on-line booking and when to offer extended hours and for how long.

Continuous improvement

- There was a strong focus on continuous learning and improvement at all levels within the practice. One GP was an examiner for the Royal College of General Practitioners (RCGP) and a Special Measures Clinical Advisor for the RCGP Practice Support Unit who assist practices who had been placed into specials measures under the CQC regime. These roles entailed being conversant with recent best practice and developments in general practice. The practice hosted student nurse placements as part of the Primary Care Education Network. The practice nurse had completed their mentoring training to support such placements.
- The practice team was forward thinking and took part of local pilot schemes to improve outcomes for patients in the area such as the medicines optimisation scheme and a scheme to help identify and educate patients who were pre-diabetic so as to mitigate the effects of the condition. In response to this two GPs and a practice nurse had had specialist training in diabetic management.
- The practice had responsibility for a number of children who were boarders at a nearby school because of this both GPs had undertaken specialist training in managing adolescent patients.
- The practice held a monthly meeting with neighbouring GPs to discuss recent published research, (the group was called the journal club), learn from safety events and share, best practice, concerns and local trends.
- There was a proactive approach to seeking out and embedding new ways of providing care and treatment. This was evidenced by the "superheroes and princesses" initiative in delivering the influenza vaccination to children. It was symptomatic of the practice that it was disappointed not to have reached its target of 75% of children vaccinated. It was similarly symptomatic that it planned to use the identified lessons learned such as, use of social media and personalised invitations across target groups, to bring these benefits to wider group of patients.