Whitstable Medical Practice

Quality Report

Whitstable Health Centre
Estuary View Medical Centre
Boorman Way
Whitstable
CT5 3SE
Tel: 01227 284300
Website: whitstablemedicalpractice.co.uk

Date of inspection visit: 21 January 2016
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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?	Outstanding ☆
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 Whitstable Medical Practice on 21 January 2016.Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. There was a very wide range of services, clinical and non-clinical. The practice was a Multi-speciality Community Provider with an ethos to bring services to the patient rather sending patients to the service.
- Feedback from patients about their care was consistently and strongly positive.
- 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. The practice was part of a Vanguard site combining with other providers to deliver services across a substantial area of East Kent.
- 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. For example walk-in surgeries and changes to the telephone response times and methods of calling patients by telephone
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had 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.

We saw several areas of outstanding practice including:

Summary of findings

- The practice had been effective in reducing the number of unplanned admissions to hospital for patients over 74 years. There was evidence to support that this was linked to the practice's initiative to a provide paramedic practitioner home visit service across the area.
- The practice had a Patient Safety and Quality Manager who was responsible for ensuring that there was a thorough analysis of the significant events.
- The practice sponsored and supported a dementia café at one of their practice sites and was developing a similar café at a second site. Here people, patients and carers, with problems related to dementia, had their emotional and social needs met as well as addressing health issues.
- The practice was trialling social prescribing with local volunteer organisations as a means of directing vulnerable patients to non-clinical services that support social, emotional or practical needs.
- The practice had played a leading role in the formation and growth of the Encompass vanguard site across a substantial region of East Kent, enhancing the range and increasing the ease of access to services. This was consistent with the practice's objective was to place the patients at the heart of the services, rather than the patients being sent round the health care system to access the services.
- Patients with complex or multiple needs were managed through integrated patient centred services, and were able to access services which would otherwise be up to an hour and a half away.
- It had a scheme for nursing and residential homes where an individual GP took responsibility. There were regular multi-disciplinary team meetings, which included a consultant geriatrician, relatives were routinely invited.
- The practice staff had undergone a number of innovative training events designed to increase staff interpersonal skills. There had been a role play workshop using actors to help improve GPs communication with patients. This was intended to reduce complaints and complaints had been reduced. The practice was involved in training at many levels and showed that as a practice they were as keen to learn from trainees as they were to teach them.

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?

Outstanding 

The practice is rated as outstanding 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. There was a genuinely open culture in which all safety concerns raised by staff and patients were highly valued as integral to learning and improvement. This was supported by the fact that the practice had a Patient Safety and Quality Manager who was responsible for ensuring that there was a thorough analysis of the significant events.

All three practice buildings were clean and well maintained. There was an annual infection control statement. Risks to patients were assessed and well managed.

Are services effective?

Good 

The practice is rated as good for providing effective services.

All the GPs and nurses were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. There were systems to help ensure that they remained so. There was evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. For example the use of the antibiotic toolkit audits from the Royal College of General Practitioners to drive change in prescribing practice leading to the reduction in the use of a particular class of antibiotics.

The patient outcomes for the practice were high, for most clinical areas, when compared to neighbouring practices in the Clinical Commissioning Group and nationally.

Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for staff.

Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' need. Where considered necessary these teams were supported by co-ordinators from the practice to help ensure the effectiveness of the multidisciplinary approach.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services.

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Data showed that patients rated the practice higher than others for all aspects of care. In the most recent independent poll of patients the practice results for all questions relating to caring were substantially better than the local and national results.

Feedback from patients about their care and treatment was consistently and strongly positive. Of the 108 patient comment cards we received 103 commented positively on the overall caring approach of the practice. We observed a strong patient-centred culture. Despite the size of the practice receptionists knew the patients well. Staff were motivated and inspired to offer kind and compassionate care, trying to ensure, for example, all patients , but particularly the elderly or vulnerable, received the most convenient appointment possible

The practice hosted, sponsored and supported a dementia café where people, whether patients of the practice or not, their friends and carers could find support that helped to meet their emotional and social needs as well as addressing health issues.

We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. This was evidenced in the comments patients had made in various surveys particularly those the practice had conducted into its outpatient services.

Views of other stakeholders, such as the clinical commissioning group, were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. The practice provided almost all services save those that needed an overnight stay or a general anaesthetic. There was an ethos of bringing services to patients rather sending patients to services.

There were innovative approaches to providing integrated person-centred care. For example a patient could see the respiratory consultant,in the co-located out-patients department, have an X-ray, the patient and consultant could discuss the results, almost contemporaneously.

The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients, the patient participation group and the friends of Whitstable Hospital. Examples included

Summary of findings

- using innovative training to reduce complaints
- the provision of an X-ray service
- Making changes to waiting areas and telephone answering systems

The practice had good facilities and was well equipped to treat patients and meet their needs. This included a Minor Injuries Unit, X-ray and other diagnostic services and a range of modern outpatient clinic rooms

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. The practice invested in training and innovative workshops to improve staff communication skills and reduce complaint. Learning from complaints was shared with staff and other stakeholders, including nearby practices and paramedical services.

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 mission statement included improving integrated care, tackling health inequalities and obtaining better value for money. The strategy to deliver this vision had been produced with other providers and was regularly reviewed and discussed with staff. It was evidenced by the practices leadership in the Encompass vanguard site.

High standards were promoted and owned by all practice staff and teams worked together across all roles.

Governance and performance management arrangements had been reviewed and took account of current models of best practice. There was corporate responsibility for governance with members of the organisation aware their responsibility to impact on it.

The practice carried out succession planning so as to take advantage of the availability of the best candidates at the time of recruitment.

There was a high level of constructive engagement with staff and a high level of staff satisfaction. Evidence from the human resources department showed that most staff retired rather than resigned

The practice gathered feedback from patients using the available technology, and it had a very active patient participation group which influenced practice development. For example influencing the provision of X-ray service and the walk-in clinics.

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.

The practice offered proactive, personalised care to meet the needs of the older people in its population. It had a scheme for all the nursing and residential homes in the practice area. This involved registering all the patients (with their consent) with one GP who looked after that home. There was better continuity of care, weekly ward rounds and better communication with the care workers. Relatives were invited to attend routine joint visits by a multidisciplinary team that included the GP, a consultant geriatrician, the medicines management and community nursing teams. The aim of this was to improve and to personalise the care of elderly patients. All these patients now have anticipatory care plans and advanced directives in place where appropriate.

Two members of the reception team had, on their own initiative, been trained to undertake simple hearing aid repairs. They provided a continuous walk-in service. This reduced the time these, mostly older, patients were without their hearing aids and reduced the incidence of isolation.

Many of the clinics provided, such as cataract surgery, echocardiography, ultrasound, dermatology, fracture and x-ray were of particular benefit to the older patients. All these clinics were available on a Saturday so that working relatives found it easier to accompany these patients.

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.

There were 10 members of the nursing team who were qualified to look after patients with long term conditions (LTC). There were GPs with special interests (GpwSI) in epilepsy, diabetes, cardiology, dermatology and respiratory medicine. A GP with a Special Interest (GPwSI) supplements their role as a generalist by providing an additional specialist service while still working in the community. This range of specialties allowed GPs and nurses within the Practice to get immediate access to expert advice without the need for the patient to wait for a secondary care appointment.

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There were clinics for patients with asthma, chronic obstructive pulmonary disease (COPD), diabetes, coronary heart disease and hypertension. In house diagnostics have much reduced the number of visits that this group of patients would normally have to make to the local general district hospital.

QOF results for patients with LTC were generally better than nationally though there were some variations.

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.

There were systems to identify and follow up children living in disadvantaged circumstances for example, children and young people who had a high number of A&E attendances or those on the local authority “at risk” register. There were positive examples of joint working with midwives, health visitors and school nurses. For example children and families at risk were discussed at a monthly meeting with health visitors.

Immunisation rates for children under five years were similar to the national averages. For one year old children the rates were generally better than the national averages.

Appointments were available outside of school hours and, in particular, clinic times were varied across the week to help ensure that families and children could attend at a convenient time. The premises were suitable for children and babies and there were changing facilities.

The walk-in surgeries from 8am to 11am were popular with families as they knew they would be seen by a GP. Patients we spoke with said that this was much easier than trying to ring in hope of getting an appointment whist trying to get children ready for school.

There was a children’s notice board at each site that informed parents of the services and clinics available at the local children’s centres. These were kept up to date by the health visitor team.

The practice wrote to patients when they became 16 years old, to check their details and particularly to ensure that the practice had the right mobile telephone number, used for notifying patients by text message.

There were collection points in the patient toilets for Chlamydia testing kits as the practice recognised that the kits are more likely to be taken by young people in a private setting. The practice had introduced telephone slots for family planning trained nurses to

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contact patients who might have questions and find it difficult to attend the surgery or who preferred to ask questions over the telephone. The practice had found that this was of most benefit to young mothers, those of working age and young people.

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 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 encouraged this group to take part in practice surveys, by the survey being available through text messaging. Patients who took part were informed, through the phrasing of the questions about current appointment systems, ways of ordering prescriptions and how to use the on-line appointment booking, prescription requests and other services through the 'Patient Access' system. The survey also alerted them to the existence of the patient participation group (PPG) and the quarterly patient newsletter.

There was a range of extended hours surgeries available. The practice varied the times of clinics throughout the week to provide the best opportunity for this group to access the services at a time convenient to them. Many of the clinics provided, such as cataract surgery, echocardiography, ultrasound, dermatology, fracture and x-ray were available on a Saturday. This often allowed carers, many of whom are from the working age population, to accompany patients to these appointments.

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 had portable hearing loops on all the reception desks. These were then available for use during GPs consultations if the need arose.

The practice had a register of patients living in vulnerable circumstances such as homeless people, patients who may be suffering domestic abuse or those with a learning disability.

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The Practice attended the local Multi Agency Risk Assessment Conferences. These occurred every other month and were organised by the police authority. Attendance allowed the practice to identify patients and families at risk of domestic violence. Therefore anyone seeing the patient was alerted, through a flag on the patient record, to the additional problems these patients might be experiencing. There was information about obtaining help and advice on domestic violence available in the patient toilets in recognition of the fact that the victims of abuse are unwilling to be seen noting such information in public.

The practice offered longer appointments for patients with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.

The practice was trialling social prescribing (social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to alternative non clinical interventions) as a means of directing vulnerable patients to various support groups and voluntary organisations. The practice recognised that it was not practicable, nor did it represent value for money, for the practice to be constantly updating lists of support organisations. It therefore used an umbrella organisation to sign post such patients to the range of possible interventions in the area.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Reception staff contacted patients who had difficulty keeping appointments, such as some patients with learning disability or dementia, a few hours before their appointments to try and ensure the appointments were not missed.

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).

Of those patients diagnosed with dementia, 80% had had their care reviewed in a face to face meeting in the last 12 months. This was in line with the national average (84%). Performance against this QOF target had been erratic over the last five years but generally below

average. For a similar QOF target, seeing patients with mental health problems each year the practice had achieved 91% and was better than the national average of 88%. The practice had bettered the national average every year for the last five years.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. When a local community venue was closed the practice provided free accommodation to the adult mental health and dementia teams so that these patients would not be forced to travel further to access services. Evidence shows that attendance at clinics and subsequent compliance with medication regimes is increased when clinics are close to where the patients live.

The practice recognised that the majority of the most complex patients were those with mental health problems. The practice had organised a mental health review meeting involving a consultant psychiatrist, community psychiatric nurses, a mental health social worker, and a representative from a local charity to see if such a multidisciplinary team can provide help and guidance on how to manage these patients. The meeting was due shortly after the inspection.

The Practice offered a memory screening programme for patients who felt they were at risk of dementia. The patients could self-refer and it was carried out at each site for the patients' convenience and in a setting that was familiar to them. Patients were able to self-refer to counselling services. The practice said that this had helped patients with mental health problems to access these services.

A GP at the practice was a GpwSI in epilepsy and some of their clinics were held in the practice to make attendance for these patients easier.

There were two dementia cafes a week held at the Whitstable Health Centre, run by the Friends Group. The practice had plans to hold a dementia café at the Estuary View site. Patients, who attended the cafes, were entering familiar territory when they came for treatment. This is recognised as an important factor in reducing the distress that both mental health and dementia patients feel when being treated in unfamiliar or alien environments.

The practice carried out advance care planning for patients with dementia, sometimes as part of the nursing home initiative.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice used an umbrella organisation to sign

Summary of findings

post patients to the range of possible interventions in the area. The practice had systems to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.	

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What people who use the service say

The most recent national GP patient survey results showed the practice was performing in line with or better than local and national averages.

- 81% found it easy to get through to this surgery by phone compared to a CCG average of 80% and a national average of 73%.
- 88% were able to get an appointment to see or speak to someone the last time they tried (CCG average 88%, national average 85%).
- 91% described the overall experience of their GP surgery as fairly good or very good (CCG average 89%, national average 85%).
- 91% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 83%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 108 comment cards. One hundred and six of these were wholly positive, two contained both positive and negative elements. The negative comments related to the age of one of the buildings.

The themes commented on positively by patients were, general care (103 comments), GP and nurse care (74), reception staff (41) and the quality and cleanliness of the buildings (28).

We spoke with patients during the inspection. All the patients said they were happy with the care they received and considered themselves fortunate to live within the practice area. Both patients and comment cards mentioned the value of having so many services close to hand. Patients and comment cards expressed the sentiment that the practice was big enough to deal with almost everything, but small enough to treat patients as individuals

Outstanding practice

We saw several areas of outstanding practice:

- The practice had been effective in reducing the number of unplanned admissions to hospital for patients over 74 years. There was evidence to support that this was linked to the practice's initiative to a provide paramedic practitioner home visit service across the area.
- The practice had a Patient Safety and Quality Manager who was responsible for ensuring that there was a thorough analysis of the significant events.
- The practice sponsored and supported a dementia café at one of their practice sites and was developing a similar café at a second site. Here people, patients and carers, with problems related to dementia, could have their emotional and social needs met as well as addressing health issues.
- The practice was trialling social prescribing with local volunteer organisations as a means of directing vulnerable patients to non-clinical services that support social, emotional or practical needs.
- The practice had played a leading role in the formation and growth of the Encompass vanguard site across a substantial region of East Kent, enhancing the range and increasing the ease of access to services. This was consistent with the practice's objective was to place the patients at the heart of the services, rather than the patients being sent round the health care system to access the services.
- Patients with complex or multiple needs were managed through integrated patient centred services, and were able to access services which would otherwise be up to an hour and a half away.
- It had a scheme for nursing and residential homes where an individual GP took responsibility. There were regular multi-disciplinary team meetings, which included a consultant geriatrician, relatives were routinely invited.
- The practice staff had undergone a number of innovative training events designed to increase staff

interpersonal skills. There had been a role play workshop using actors to help improve GPs communication with patients. This was intended to reduce complaints and complaints had been reduced. The practice was involved in training at many levels and showed that as a practice they were as keen to learn from trainees as they were to teach them.

Whitstable Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, three further CQC inspectors, a practice manager specialist advisor and a practice nurse specialist advisor.

Background to Whitstable Medical Practice

Whitstable Medical Practice is a GP practice located in the town of Whitstable Kent. It provides care for approximately 35000 patients. The practice is in a predominantly urban area.

There are 15 GP partners and five salaried GPs. There are 31 practice nurses, with varying qualifications such as Advanced Nurse Practitioners and nurse prescribers, supported by a team of healthcare assistants.

The age of the population the practice serves is close to the national average for patients up to 64 years of age. There are 46% more patients aged between 65 and 75 years than the national average. There are nearly 50% more patients aged between 75 and 85 years than the national average. There are 64% more patients over 85 years than the national average.

Income deprivation and unemployment are low both being about two thirds of the national figure.

In March 2015 Whitstable medical practice was one of three local founding practices to become a Vanguard site. Vanguard sites are being developed as part of implementing the NHS Five Year Forward View. Part of the objective is to support improvement and integration of services. Whitstable's particular Vanguard site is called Encompass. On its launch it covered a practice population of some 53,000 patients but has since expanded to cover about 170,000 patients. It is a partnership with local health, care and support organisations including Canterbury & Coastal CCG, Kent County Council, East Kent Hospital University Foundation Trust, Kent Community Health NHS Foundation Trust, Kent Partnership Trust and AgeUK. However this report deals with the services provided by the Whitstable Medical Practice in its own right.

The practice has a personal medical services (PMS) contract with NHS England for delivering primary care services to local communities. The practice also offers a wide range of other services under a number of different contract types. The practice is a teaching practice teaching trainee doctors, nurse, paramedics and medical students. It is a training practice, providing training for qualified doctors to become GPs.

The practice is open between 8.00am and 6.30pm Monday to Friday. There are regular extended hours surgeries between 7am and 8am and 6.30pm and 7.30pm. The practice runs a minor injuries unit, patients can be seen there between 8am and 8pm 365 days of the year.

The practice has three purpose built healthcare centres within the town namely:

Estuary View Medical Centre

Boorman Way

WhitstableCT5 3SE

01227 284300

Whitstable Health Centre

Harbour Street

WhitstableCT5 1BZ

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01227 284320

Chestfield Medical Centre

Reeves Way

ChestfieldCT5 3QU

01227 795130

We visited all three sites in the course of the inspection.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by Integrated Care 24 Ltd. There is information, on the practice buildings 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 inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

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

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

The visit was announced and we asked the practice to place CQC comment cards in the practice receptions so that patients could share their views and experiences of the service before and during the inspection visit. There were comment cards at all three sites. We carried out an announced visit on 21 and 22 January 2016. During our visit we spoke with a range of staff including partner GPs, GP registrars practice nurses and healthcare assistants, the practice manager, department heads, receptionists and administrators and data inputters. We spoke with patients who used the service.

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

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

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

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

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.

Outstanding ☆

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. For example, significant events or incidents and national patient safety alerts as well as comments and complaints received from patients or other providers. There was a significant event recording form available to staff on the practice's intranet. Staff we spoke with knew how to report events and did so.

The practice had a Patient Safety and Quality Manager who was responsible for ensuring that there was a thorough analysis of the significant events. We looked at several events in detail. One concerned vaccination errors. Initially the practice put up notices and increased appointment times to reduce the errors. This was successful but not sufficiently so to satisfy the practice. Staff therefore had comprehensive training. The training comprised an audit of errors, identification of common errors (and the reasons for them) and the introduction of a template before delivering vaccines. Since then there had been only one similar error.

We reviewed safety records, incident reports national patient safety alerts and the minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we talked with administration staff who told how us they had been involved in improving systems to reduce the incidence of missed referrals. We saw that in appropriate cases significant events were fed back to other providers, such as the local hospital and recorded on the National Reporting and Learning System (this is a system designed to identify hazards, risks and opportunities to improve the safety of patient care).

Staff anticipated and managed risks to patients and thought about safety when considering the use of or changes to systems. For example some summaries of patients' tests had to be copied, a duplication of work which staff recognised increased the chances of errors. Though there had been no incidents, this was raised at the weekly clinical meeting and a solution agreed upon.

When there were notifiable safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had well defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.

There were arrangements to safeguard vulnerable adults and children from abuse that reflected relevant legislation and local requirements. All the GPs were trained to the appropriate level (level three) in child safeguarding. There were policies which guided staff in safeguarding matters. There were notices directing staff on whom to contact in order to report such matters. There was a practice lead (a GP) for safeguarding and staff knew who this was. GPs attended safeguarding meetings or provided reports if they were not able to do so. Staff demonstrated they understood their responsibilities and had received training relevant to their role. Staff told us about specific (anonymised) incidents that had been reported and investigated in accordance with the protocols. There were examples of both children and adult safeguarding referrals.

An Emergency Nurse Practitioner who is the practice's domestic abuse co-ordinator attended the local Multi Agency Risk Assessment Conferences. These occurred every other month and were organised by the police authority. Attendance allowed the practice to identify patients and families at risk of domestic violence. Therefore anyone seeing the patient was alerted, through a flag on the patient record, to the additional problems these patients might be experiencing. There was information about obtaining help and advice on domestic violence available in the patient toilets in recognition of the fact that the victims of abuse are unwilling to be seen noting such information in public.

There were notices in the waiting room and in consultation rooms, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones had received an enhanced disclosure and barring check (DBS). These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or vulnerable adults.

The practice had a lead for infection control who had undertaken advanced training to enable them to provide advice to the practice infection control and carry out staff training. There were also leads for infection control at each site and these had also had advanced training. Staff we spoke with knew who the lead, or lead for their site, was.

Outstanding ☆

Are services safe?

Staff received induction training about infection control specific to their role and received annual updates. There was an annual infection control statement setting out any issues that had arisen over the previous year and infection control plans for the forthcoming year.

Infection control policy and procedures were available to staff, this helped enable them to plan and implement measures to mitigate the risks of infection. Cleaning schedules and cleaning records were kept. These were available in the clinical rooms and those we examined were up to date. Recent infection control audits had been done and plans to address the issues were being drawn up but were not yet complete. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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 and temperatures were checked regularly. There was guidance on the action to take in the event of a potential failure.

There was a monthly stock check of all injectable medicines and vaccines. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Regular medication and prescribing reviews were carried out with the support of the clinical commissioning group (CCG) help to ensure the practice was prescribing in line with best practice guidelines. The patterns of hypnotics, sedatives and anti-psychotic prescribing were within the range that would be expected for such a practice.

Prescriptions were checked and signed by GPs before medicines were given to patients. The nurses and the health care assistants administered vaccines using patient group or patient specific directions that had been produced in line with legal requirements and national guidance. Prescription pads were securely stored and there were systems to monitor their use.

We reviewed a range of personnel files from different departments within the practice. 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 DBS checks.

There were robust systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

There were processes for monitoring and managing risks to patients and staff. There had been a recent fire risk assessment. Staff had received regular fire safety training. There were regular fire drills. We saw that there had been an unplanned evacuation, following an incident in one of the kitchens. The evacuation had tested staff training and had gone well.

There was a system governing security of the practice at each of the three sites. Visitors were required to sign in and out at reception. The staff reception area in the waiting room was always occupied when patients were in the building. Electrical equipment had been tested for safety and equipment which needed regular calibration had been calibrated. There were assessments for other risks such as for the control of substances hazardous to health and legionella. There were spills kits on hand in the event of accidental contamination.

There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. For example there were staff providing a mix of services across the three sites and staff at the minor injuries unit from 8am to 8pm each day of the year.

Arrangements to deal with emergencies and major incidents

All front line staff received annual basic life support training and there were emergency medicines available at each site. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency medicines we looked at were in date and checked regularly together with the emergency equipment. Each site had a defibrillator and medical oxygen with adult and children's masks.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The practice had three operational sites and much of the planning involved using the unaffected premises to reduce the impact of the event on the care to patients.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) and other guidelines and had systems to ensure all clinical staff were kept up to date. There was a clinical meeting each Monday lunchtime where such guidelines, and how they could help in individual cases, were discussed. For example we saw minutes that showed that three new guidelines, two relating to diabetes and one to coeliac disease were discussed. The practice used the Cardiff health check protocol as guidance when conducting annual health checks for patients with a learning disability. This protocol is part of the Royal College of General Practitioners guidance.

The practice had access to guidelines from NICE and guidelines about other local practice such as local referral pathways. The practice used this information to develop how care and treatment was delivered to meet needs.

There was a range of templates available to staff to help steer them though implementing the guidelines appropriately. For example, the practice implemented NICE guidance by using ambulatory blood pressure monitoring for patients with suspected hypertension (raised blood pressure).

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 results, for the financial year ending March 2015, showed that the practice had attained a score of 99.8% on the clinical measures.

QOF performance for patients with chronic obstructive pulmonary disease showed that 88% had received the annual review that was recommended, this had fallen from 95% over the previous two years, and was now slightly below the national average of 90%.

Similar figures for diabetic patients, for patients receiving an annual foot examination showed that about 93%, against a national average of 88%, had had that review. The practice had consistently bettered the local and national averages over the last five years. The QOF measures for diabetes are numerous and complex however, using an amalgamated overall figure, the practice results had been better that the national average every year for the last five years by between 2% and 9%.

For mental health on another annual measure, patients who had received an individual care plan, the outcome was 91%. This was better than the national and local averages and had been so for the last five years. About 80% patients with dementia had had a face to face review this was slightly below the local and national averages and had been so for the last five years.

For patients suffering from asthma 71% had received an annual asthma review in line with best practice. This was slightly below the national average and had been so for the last five years.

Exception reporting (the removal of patients from QOF calculations for various reasons) was generally in line with or slightly below the national and local figures.

Clinical audits demonstrated quality improvement. Clinical audits were a standing item on the clinical meeting agenda. This had been done to raise awareness and to avoid duplication. There were several completed audits and others in progress.

For example, in May 2015, there had been an audit into the monitoring of diabetic patients who were prescribed steroids in the long term. This had identified deficiencies in the process of monitoring, in particular in carrying out regular checks of patients' glucose levels every three months. This had been discussed at clinical meetings. The audit was repeated in September 2015 and there had been a very marginal (6%) improvement in the number of patients receiving a blood glucose test. In response to the audit, there were plans to increase effectiveness by using the GPs individual list to identify relevant patients. The practice planned to repeat the audit next year.

Findings were used by the practice to improve services. For example, a recent audit had identified high usage of a particular class of antibiotics. The audit used antibiotic toolkit audits from the Royal College of General Practitioners. The findings were presented at the clinical meetings and this led to a reduction in the use of those antibiotics.

Good

Are services effective?

(for example, treatment is effective)

The practice had been effective in reducing the number of unplanned admissions to hospital for patients over 74 years. In 2013/14 there had been 730 such admissions. In 2015/16 (comparing year to date) there had been 673, a fall of 8% during the same period the number of patients over 74 years had risen by 5%.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Records showed there was an overall training plan. Mandatory training such as information governance, basic life support and infection prevention control had been completed by all staff. Where there were gaps, such as arose through maternity leave or other staff absence the practice was aware and were addressing them.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. Nurses told us of the opportunities available to them to advance their professional qualifications. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.

Administrative staff also felt there were substantial opportunities for training and many staff had taken advantage of this, for example training in areas such as human resources and information technology.

The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We saw examples of staff induction records and these had been completed to a high standard. Staff we spoke with said that their induction had been thorough. All available staff had had an appraisal within the last 12 months. All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager.

Coordinating patient care and information sharing

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and other correspondence both electronically, by fax and by post. Staff knew their responsibilities in dealing with any issues arising from these communications. There were systems within the practice's electronic patient record to allocate workflow such as allocating tasks to individuals. We looked at some of these and saw the practice were aware of individuals' workflow, clinicians generally completed their workflow before the end of the working day, in accordance with the policy, when this did not happen the practice were aware and took remedial action.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan their care and treatment. This included when people moved between services. The practice constructively challenged other organisations when arrangements did not work well. For example the practice wrote to another provider requiring an explanation when a commitment to the care of a vulnerable patient was not met.

There was a range of regular multidisciplinary meetings which included community health services such as district, palliative and psychiatric nurses, local social services and various disciplines from within the practice. There was a specific palliative care meeting every quarter. Attendees included doctors and nurses from the local hospice, community long term conditions, heart failure and respiratory nurses, GPs and registrars from the practice. Minutes were taken and the practice had appointed a palliative care administrator. Their task was to ensure that the actions assigned to different attendees were carried out and that patients receiving palliative care had access to the services they needed.

Information was shared with the paramedic service. For example we saw that a significant event that had had implications for GPs as well as the paramedic service had been jointly discussed.

The practice worked with local diabetic services to provide retinal screening to patients where this was indicated. Retinal screening is designed to detect early signs of damage to the retina of the eye which can result in blindness.

The practice was a leading partner in Encompass the local multi-speciality community provider. This involved working with 16 other GP practices, the Clinical Commissioning Group (CCG), three other NHS trusts, the local council and local social services, the local hospice and numerous voluntary groups.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

All GPs, nurses and administration staff had received training in the Mental Capacity Act 2005 (MCA) appropriate to their roles. We were told of examples of best interest meetings to decide on the treatment of patients who did not have capacity to make those decisions needed and how the MCA had been used to achieve this.

The practice had a policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded. We saw that consent was specifically recorded for invasive procedures such as minor surgery.

Supporting patients to live healthier lives

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. They were all offered an annual physical health check.

As part of the Encompass initiative the practice was involved, with Public Health England in developing local public health trainers. Health trainers help people to assess their lifestyles and wellbeing, set goals for improving their health and provide practical support that may help people to change their behaviour. Also as part of Encompass the practice was developing social prescribing services. Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical interventions often provided by the voluntary and. community sector, such as psychological or weight management services.

Patients were encouraged to participate in national screening initiatives such as abdominal aortic aneurysm screening (a way of detecting a dangerous swelling of a major blood vessel), bowel cancer screening and cervical cancer screening. The practices results for cervical screening were 83% (of the total who met the criteria for screening) this is in line with results nationally.

The practice hosts the Guy's genetic screening programme. This is a service to diagnose and assess the risk of patients or their family inheriting a genetic condition. Whilst it sometimes cannot lead to a specific diagnosis, it is used to help patients and GPs understand a possible diagnoses and treatment options..

Childhood immunisation rates for children under 5 years were similar to the national averages. For one year old children the rates were generally better than the national averages, for example, ranging from 95% to 97% against a national performance of 89% to 94%. Influenza vaccination rates for the over 65s were 68%, and for at risk groups 44%. These were slightly lower than the national averages of 73% and 47%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. These appointments were for 30 minutes each and the specific findings were followed up. For example

- patients with a raised blood pressure were asked to attend for two further blood pressure readings
- Referral to the practice's nurse led stop smoking service
- Referral directly to the local lifestyle management team (an example of social prescribing) who provided exercise advice and weight management. This service had had excellent feedback for from patients.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey. We spoke with patients and read the comment cards that patients had completed. We saw that members of staff were always courteous and very helpful to patients. This evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Patient confidentiality was respected. There were private areas, off reception, where patients could talk to staff if they wished. Some of the reception areas were open plan. Where this was the case the practice had put in shoulder high office dividers. These acted as screen both visually and for conversation. They funnelled the patients towards the reception desk. There were notices asking patients not to enter the funnel area until the patient in front had been dealt with. This improved patient confidentiality.

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

Despite the size of the practice list we saw that receptionists often knew patients well. We heard receptionists listening to patients talk about family news, we heard them asking patients if they wanted them to call for their "usual" taxi service and heard them signposting patients towards specific relevant support services.

Patients completed 108 CQC comment cards to tell us what they thought about the practice. We also spoke with 27 patients during our inspection. Both the comment cards and what the patients said were positive. There were no negative comments about the care provided.

Patients said they were very pleased with the care, they said that staff often went beyond what could be ordinarily expected, to help meet patients' needs. Patients told us how GPs and nurses had acted to expedite their referrals.

We heard examples of this when reception staff moved appointments, particularly for elderly patients, making the appointments "back to back", so as to reduce the number of times the patient needed to come to the practice.

Other general themes commented on included the care and attention of staff, the diagnostic skill of GPs and nurses and the quality of organisation at the practice. Many patients commented on the range of services that were available within the practice without having to go to hospitals or other providers.

We spoke with five members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They said that the practice was innovative and forward thinking.

Results from the National GP Patient Survey showed patients felt they were treated with compassion, dignity and respect. The practice was consistently above average for its satisfaction scores on consultations with GPs and nurses. It was significantly better for its satisfaction scores on the helpfulness of receptionists.

- 94% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%. When asked the same question about nursing staff the results were 96% compared to the CCG average of 94% and national average of 91%.
- 91% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%. When asked the same question about nursing staff the results were 98% compared to the CCG average of 94% and national average of 92%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%. When asked the same question about nursing staff the results were 99% compared to the CCG average of 98% and national average of 97%.
- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%. When asked the same question about nursing staff the results were 96%compared to the CCG average of 93% and national average of 91%.
- 96% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Outstanding ☆

Are services caring?

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. We saw that GPs and nurses used tools such as charts and models to help patients understand the issues and therefore make more informed choices. Patient feedback and feedback from the comment cards supported these views.

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 better than local and national averages.

- 91% said the GP was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%. When asked the same question about nursing staff the results were 94% compared to the CCG average of 92% and national average of 90%.
- 88% said the GP was good at involving them in decisions compared to the CCG average of 85% and national average of 82%. When asked the same question about nursing staff the results were 91% compared to the CCG average of 87% and national average of 85%.

There were translation services for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

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

There was a register of carers of the practice's computer record it comprised 298 patients, about 1% of the patient list. The system alerted GPs if a patient was also a carer. There were template letters sent out to patients and their carers inviting both to a consultation with their GP, in appropriate cases. There was a practice questionnaire available for carers to complete so that the practice had the correct information to hand to help support them. The practice had produced a leaflet for carers to help to direct them to various avenues of support. There was information available to carers on the practice's waiting room television screen.

The practice hosted a dementia café in the Whitstable Health Centre. This was run in conjunction with a local charity and a charity specifically involved in helping those with dementia. The café offered a drop-in facility for anyone who might need support, information and advice about dementia. This included families and carers as well as those with the disease. It provided the opportunity to gain access to health and social care professionals and voluntary organisations providing support. There were dementia peer support groups available on certain days. We watched the café at work and the people using it. It provided a light and cheerful place where people, patients and carers, with similar problems, had their emotional and social needs met as well as addressing health issues.

There was a protocol for staff to follow when families suffered bereavement, the practice contacted them or sent a letter. Families were afforded a consultation at a time and location to meet their needs, if required. There was advice on how to find a bereavement support service.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to need and accessing services

The practice was open between 8am and 6.30pm Monday to Friday. There was a range of services and appointments available. Appointments were pre-bookable with GPs up to two weeks in advance. There were telephone consultations available both for pressing problems on the day and as pre-bookable appointments with a named GP.

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

- 86% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 81% patients said they could get through easily to the surgery by phone (CCG average 80%, national average 73%).
- 72% patients said they always or almost always see or speak to the GP they prefer (CCG average 65%, national average 59%).

Whilst patients could see any GP or attend any practice building the GPs had individual patients' lists. This helped to promote individual continuity of care. Patients told us at the inspection that they were able to get appointments when they needed them. There were facilities for disabled patients, portable hearing loops and translation services.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. This included having a leading role in the formation and growth of the Encompass vanguard site across a substantial region of East Kent.

There was a "walk-in" surgery available at each site, each day between 8am and 11am. No appointment was necessary. If more than 30 patients booked into the walk-in surgery the additional patients were divided between the remaining GPs who were finishing their morning surgery.

There were regular extended hours surgeries between 7am and 8am and 6.30pm and 7.30pm across all three sites. These services were available by appointment and were there primarily to help patients who had difficulty in attending during normal working hours.

There were longer appointments available for patients who needed them such as those with a learning disability or other complex issues. Home visits were available for older patients and patients who would benefit from them. There was a paramedic practitioner home visiting service. This was now managed by the Vanguard to which the practice belonged. However it had been initiated and run by Whitstable Medical Practice from April 2015 – November 2015. Paramedics would only visit when and if the GP felt the case was appropriate, or if an urgent visit was required and no GP was immediately available. We were told that there was strong support for the service from the public and GPs. Evidence showed that it had reduced by 15% conveyances by the ambulance service to Accident and Emergency (A&E). There was other evidence that when admission to A&E was necessary having paramedics improved the speed and process of admission.

Same day appointments were available for children and those with a pressing medical need.

The practice had initiated a scheme for all the nursing and residential homes in the practice area. This involved registering all the patients (with their consent) with one GP who looked after that home. There was better continuity of care, weekly ward rounds, and better communication with the care workers. Relatives were invited to attend routine joint visits by a multidisciplinary team that included the GP, a consultant geriatrician, the medicines management and community nursing teams. The aim of this was to improve and to personalise the care of elderly patients. All these patients had anticipatory care plans and advanced directives in place where appropriate.

The practice had developed a wide range of other services for patients. The practice objective was to place the patients at the heart of the services, rather than the patients being sent round the health care system to access the services. These services were provided by the practice alone or in partnership with other providers such as the local hospital. Often the services were provided by GPs with special interests in the area of treatment concerned. The services were flexible provided choice and helped to ensure continuity of care. All were provided in Whitstable. The services included, but were not confined to:

- Insulin initiation clinic
- Warfarin clinic
- Cardiology clinic
- Epilepsy clinic

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Cardiac rehabilitation
- Local steroid injection clinic
- Hearing aid clinic
- Dermatology clinic and
- Ear, nose and throat clinic.
- DVT (Deep Vein Thrombosis) – Diagnostic and treatment service

There were diagnostic services including

- Echo cardiology
- Ultrasound
- Digital X-ray and
- Magnetic image resonance screening (a visiting service)

There were consultant led out-patient clinics including

- Cardiology
- Gynaecology and
- Dermatology

There was support for musculoskeletal problems including

- Acupuncture
- Chiropractic
- Physiotherapy

Some services were provided with the involvement of other organisations and the local community. These included the cataract day surgery, hosted by the practice and provided by consultant ophthalmologists and the Dementia Café provided with the help of local charities. There was a seven roomed outpatients suite where the local hospital trust provided a further 17 specialities. Patients with complex or multiple needs were managed through integrated patient centred services.

There was a minor injuries unit (MIU). This was open 8am – 8pm every day including Bank Holidays. This service was run by the practice's emergency nurse practitioners and a full support staff. The MIU was supported by an X-ray suite open for the same hours.8.00a.m. – 8.00p.m. 365 days a year. The x-ray suite was also available for referrals from GPs and Consultants. For example on days when there a visiting respiratory consultant the x-ray suite kept a number of appointment slots free. The patient could see the consultant, have any X-ray, if necessary, almost immediately. The X-ray was digitally posted to the consultant. The patient and consultant could discuss the results, again almost immediately. The practice had recently decided to keep the X-ray service open to patients from surrounding services despite the fact that there was no requirement to do so.

Listening and learning from concerns and complaints

There was a complaints policy which included timescales by which a complainant could expect to receive a reply. There was a Patient Safety and Quality Manager designated to manage complaints. Information was available to help patients understand the complaints system in the form of leaflets, notices and material on the website.

The practice saw complaints (and significant events) as opportunities for learning. Learning we saw included, improving communication, better consideration of patient confidentiality issues as well learning from clinical issues.

The practice reviewed complaints thoroughly. There had been 38 complaints during the calendar year 2015. The practice had upheld 21 and not upheld 17. The number of complaints had fallen from 43 the previous year despite an increase in list size.

The practice believed this was due to a number of initiatives, brought in in 2015. For example complaints were now discussed at the monthly business meeting for GPs, at clinical governance, nurses and supervisors meetings as appropriate. The practice had purchased a number of training events including some designed to increase staff skills in communication and dealing with difficult people. There had been a role play workshop using actors to help improve GPs communication with patients.

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 had a mission statement which was displayed on the television screens in the waiting areas, in some of the staff areas and on the website. It formed part of the practice's statement of purpose. The statement encompassed values such as acting with integrity, acting on concerns about patient safety, commitment to continuous learning and delivering the best possible care in the correct setting for the individual patient. It included working with other organisations to improve integrated care, tackle health inequalities and obtain best value for money. The objectives were challenging and innovative and included being able to provide all health and care services which did not require an overnight stay or general anaesthetic.

Staff we spoke with knew about and were committed to the practice ethos.

There was commitment to improving the patients' experience of care and to engaging with their patient participation group to ensure the services being delivered meet the needs of the local population. There had been a planned approach to the development of the practice, for example the three practice sites formed a triangle across the town. This had not been by chance but because the practice had chosen the new sites with a view to ensuring it was as accessible to its patients as was practicable. The Estuary View site had been developed where it was, in part, to service the needs of a large planned housing development nearby.

The practice was proactive in planning workforce succession. The practice had recently advertised a single vacancy. There had been two outstanding candidates. The practice had taken on both because it had foreseen that there would be a need for the second individual albeit not for some time. The practice thought strategically and did not want to lose the second candidate despite the additional costs.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and of good quality care. There were documents that set out the leadership structure with individuals allocated various areas of responsibility. For example there was a finance partner, a chairman, a clinical lead, a lead for GP training and managing partner for staff. On the administration side there was a lead practice manager with sub departments such as, human resources and information technology.

There were practice specific policies acted upon by staff. They could be accessed through the practice's intranet. The practice undertook a range of risk assessments. We saw building risk assessments such as those relating to fire risks. We saw risk assessments such as those relating to an individual's workplace. For example one had resulted in some shelves being moved and a new chair provided. The practice had recognised that an individual's workplace was important to their health, safety and productivity, each relevant staff member had had an individually tailored support made and installed that kept their computer screen at the height most suitable for them.

We looked at a number of meeting minutes including but not confined to clinical meetings and significant event meetings. The practice was open to suggestion, for example following a review of infection prevention control the practice appointed a lead nurse for infection control, with additional leads on each site. The appointed staff members had all received specialist training and there had been individual audits for each site. At the suggestion of the infection control leads a GP was as appointed as a point of contact for each site, so that matters of infection control could be easily raised at the correct level within the organisation.

Guidelines from the National Institute for Health and Clinical Excellence and other new guidelines and best practice were discussed at the weekly clinical meeting.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. As the practice was very large there was a governing board. All the partners were asked to provide items for the board agenda and were notified of the agenda items in advance of meetings. There was a subsidiary range of meetings including, business meetings, clinical governance meetings, nurses and supervisors meetings, administrators and receptionists meetings.

Are services well-led?

Outstanding ☆

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

There was a set of corporate rules for the partners, these included treating others with respect, arriving at meetings on time, responding to staff questions in a timely and polite manner and accepting personal responsibility for their work.

Despite the fact there were over 100 employees, 90% of them part time, all of the staff we spoke with felt that communication was excellent. Staff knew of, and understood the reasons for, change. They were aware of the key issues such as significant events, safety, dignity and equal treatment. Clearly not all staff were aware of all issues but staff knew of the main issues affecting the practice and of the issues relevant to their area of work. This applied across the practice from data inputters to partners. Means of communication included, emails meetings, one to one supervisions and a weekly newsletter, distributed by e-mail. Topics we saw in the newsletter included general developments, staff birthdays, charity events and the forthcoming inspection by the Care Quality Commission.

We looked at the minutes of a number of meetings and saw that they were effective. For example we saw minutes from a partnership meeting where complaints were discussed. The specific learning from the complaint had been shared and, because it was also a significant event, a significant event form had been completed. Actions arising from meetings were allocated to individuals, this was recorded on the meetings' minutes and the actions were followed through until signed off as completed. The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty.

There was a clear leadership structure and this was set out in documents available to staff. Staff felt supported by management. There was a senior executive partner, a chairman and clinical lead and leads for finance, training, and human resources. Therefore staff were able to see who was responsible for different areas of activity should they have a problem they wanted to discuss. Staff told us that they could discuss problems with any of the practice leadership but would generally go to the responsible individual.

Staff told us they were supported by the management. We saw an example where, following an incident, a staff member had lost confidence and expressed doubts about being able to carry out a particular procedure. The staff member had been supported and coached to a standard where they had been successfully re-assessed and now carried out the procedure routinely.

There were regular team meetings. Staff told us how they had influenced the running of the practice though the meetings. For example there had been changes to how referrals were managed as result of staff suggestions. These changes related to how codes were used by GPs and when the changes were not effective enough staff felt quite entitled to raise the issue again with the management at the meetings until it was satisfactorily resolved.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. Patients were asked to provide feedback through the practice's website, through the patient participation group (PPG), through suggestions boxes and through in-house and other surveys. These surveys included, but were not confined to:

- Paramedic home visiting scheme
- Minor Injuries Unit
- Cataract services
- Audiology
- Ultrasound
- Individual GP patient surveys

Patent satisfaction was very high, for example all the patients surveyed about the paramedic service were satisfied with their treatment and were "happy" with the service. The practice responded to issues raised. Examples included

- Improving the range and quality of reading material in the waiting rooms
- to response times for answering the telephones.
- Patients commented that the lack of caller ID display on their telephone had put them off taking a GP call (they thought it was a sales call). The method of calling had been changed to prevent this.

When there was confusion, following press reports, about public transport to the Estuary View site, the PPG undertook a patient survey on public transport. As a result of this the PPG produced a summary of transport services

Are services well-led?

Outstanding ☆

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

and timetables. This was circulated to patients through meeting minutes and a newsletter, as a result patients, particularly those who had read the press reports, were more reassured as to the accessibility of the service.

Community involvement had been key to providing and supporting the services the practice offered. For example the Friends of Whitstable Hospital had been central in raising funds and driving forward the X-ray facility. The dementia café was hosted and sponsored by the practice but with the support of community organisations.

The PPG were very involved in the development of the walk-in clinics. The group helped to identify patients' needs, promote the service, produce a leaflet about it and assisted with the practice's telephone message and website information about the service.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of both local and national pilot schemes to improve outcomes for patients in the area. For example the initiative to improve care in the local nursing and residential homes, discussed above, had been adopted by the CCG as a local enhanced service.

The practice was a leading partner a successful bid to become a vanguard site now established as Encompass. The purpose of this was to develop a new model of care, in line with the NHS Five Year Forward View, with the practice as a multi-speciality community provider (MSCP). As an MSCP the practice had brought together nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. This had brought a great many outpatient consultations and the ambulatory care of the patients in Whitstable to Whitstable. Surveys of patients and results from the NHS friends and family tests show very high levels of satisfaction with this approach.

There was a regular "Town Team" meeting for services within the town of Whitstable, it involved town GP practices, the Clinical Commissioning Group and other local clinical organisations. The objective was to share best practice, discuss new services and share information about changes to the locality. It was led by Whitstable medical practice.

The practice was an accredited training practice and teaching practice. There were five qualified GP trainers at the practice. As a training practice, it was subject to scrutiny and inspection by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. Therefore GPs' communication and clinical skills were regularly under review. There were four qualified nurse mentors and regular in-house nurse training, including external speakers and access to local and national courses.

There was training for medical students and we saw that there was comprehensive four week programme that included auditing, clinic work and sitting in on GP consultations. There was an assessment at the end of the process which included what the practice had learned from the student as well as the reverse. GP registrars told us that the practice was as keen to learn from them as it was to teach them.

The practice was involved, with other members of the Encompass in the development of a Community Educational Provider Network (CEPN). The role of the CEPN is to build capacity and capability for education and training in primary care and community settings to support general practice.

Other initiatives the practice was involved in included, but were not confined to:

- The development of a new local community hospital.
- The building of a teaching nursing home
- A care home project where individual GPs worked with specific care home to improve care, manage multi-disciplinary team visits and reduce admissions to hospitals.
- The triaging of orthopaedic referrals to help ensure patients see the right clinician the first time.
- SHREWD – a system of coordinating information about pressures on the local healthcare systems such as emergency care, so that staff across the system are made aware, in real time, of mounting pressures and can execute pre-planned contingencies to share the burdens more evenly.
- WAITLESS – a mobile platform to provide patients with real time information about waiting times at Accident and Emergency (A&E), Minor Injuries Units and primary care services across a geographical area. It has a triage function and gives patients the ability (and directions to) to another less busy unit which might suit their needs.

Are services well-led?

Outstanding ☆

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

These initiatives were all in line with the practice's professed aims to improve care, bringing the right care, from the right service at the right time to the patient, locally.