Minster Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Minster Medical Centre on 26 March 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP or nurse, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly the provider should

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP or nurse and there were urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence of learning from complaints.

Summary of findings

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems to identify and follow up children living in disadvantaged circumstances or who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were exceptionally high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. There was evidence of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and this had been offered to all these patients. It offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had provided information to vulnerable patients about how to access various support groups and voluntary organisations. 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 97% of patients experiencing poor mental health had received an annual physical health check and 92% have a comprehensive care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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

Summary of findings

What people who use the service say

We spoke with six patients. We received 35 completed comment cards.

All the patients were pleased with the quality of the care they had received. The themes running through the comments cards and the patient interviews were that GPs and nurses listened and gave patients enough time to express themselves.

Several patients said that clinical problems had been picked up by GPs and nurses early and this had helped with their treatment. Patients said that it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment.

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 228 survey forms were sent out and 123 were returned. The main results from that survey were:

What the practice does best

- Patients found it easy to get through to the surgery by telephone
- Patients said that their overall experience of making an appointment was good
- Patients said that their overall experience of the practice was good

What the practice could improve

- Only 48 % of patients with a preferred GP usually get to see or speak to that GP, compared with 54 % in the local area.

Seventy nine percent of patients would recommend this surgery to someone new to the area.

Areas for improvement

Action the service SHOULD take to improve

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

Minster Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Minster Medical Centre

The Minster Medical Centre is a GP practice located in an urban area of the Isle of Sheppey in Kent though it has both urban and rural patients. It provides care for approximately 6000 patients. The practice population is similar to national averages. It has marginally more patients over 65 years than the national average.

It is not an area of high depravation or of income deprivation. The number of people in paid work or full time education is about three quarters of the national average. It has about 50 % more people receiving disability allowance than nationally. The area has more people with a long-standing health condition, with health-related problems in daily life and with a caring responsibility than nationally. It has significantly more nursing home patients than the national average.

There are four GP partners, one female and three male.

The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities and an alternative medical provider service (APMS) contract in respect of other services including GP services to Her majesty's Prisons on the Isle of Sheppey.

Services are delivered from:

Sheppey Community Hospital,

Plover Road,

Minster on Sea,

Minster,

Kent.

ME12 3LT.

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care. Out of hours care is provided by Medway on Call Care (MedOCC).

Why we carried out this inspection

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

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

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

Detailed findings

How we carried out this inspection

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

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

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the 26 March 2015. During our visit we spoke with a range of staff including GP partners, salaried GPs nurses and healthcare assistants, receptionists and administrators. We spoke with patients who used the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve 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. The staff we spoke with understood the policy relating to significant events and were aware of their responsibilities to raise concerns. They knew how to report incidents and near misses. There was a wide range of significant events recorded by the practice which included clinical issues as well as administrative issues such as failures in technology. For example we saw that there had been an issue relating to the security clearance of staff working in prisons and as a result the practice had changed their practice for checking staff documents.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. There was regular reporting of events. There was an open approach to reporting incidents and there was evidence of learning from them.

Learning and improvement from safety incidents

There was a culture of openness to reporting and learning from patient safety and other incidents. The practice had a system for reporting, recording and monitoring incidents, accidents and significant events. All staff we spoke with were aware of how to report incidents, accidents and significant events.

The practice investigated incidents, accidents and significant events. All reported incidents, accidents and significant events were managed by designated staff. Feedback from investigations was discussed at significant event meetings and staff meetings. We saw that where the practice had made a mistake it acknowledged this, apologised and offered redress where appropriate.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that all the GPs were trained to the appropriate level (level 3) in safeguarding children. GPs had also completed training in safeguarding adults. There was a lead GP for safeguarding both children and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They knew who the lead was for safeguarding and to whom these should be reported. Staff had been trained to the appropriate level, level 2 for nurses and level 1 for others. There was access to information at various places within the practice to remind and inform staff about the processes to be followed in reporting a safeguarding. Staff told us of incidents that had been correctly reported and investigated in accordance with the protocols. There were examples of both children and adult safeguarding referrals.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans.

There was a chaperone policy. There were posters about chaperoning displayed on the waiting room noticeboard and in consulting rooms. There were sufficient staff trained to act as chaperones. Where a chaperone was used this was noted on the patient's record.

Medicines management

Medicines kept in the treatment rooms and medicine refrigerators 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, there were both physical checks and remote sensors to monitor this. There was guidance on the action to take in the event of a potential failure. There had been a power failure which had affected the storage of the vaccines and medicines. This had been recorded as a significant incident and staff had followed the correct policy.

A designated nurse was responsible for stock control. They ensured that only a limited amount of medicines and vaccines were kept on the premises and reordered frequently. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The patterns of hypnotics, sedatives and anti-psychotic prescribing were within the range that would be expected for such a practice. The nurses and the health care assistant administered vaccines using patient group directions that had been produced in line with legal

requirements and national guidance. We saw up-to-date copies of directions for various medicines. The nurse administering the vaccines was authorised to prescribe them.

Patients were able to obtain repeat prescriptions either in person, on-line or by completing paper repeat prescription requests. The practice had a system that helped ensure patients' medicines reviews were carried out at regular intervals and in response to changes in local and national guidance. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The premises were clean and tidy. The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with personal protective equipment (PPE) including a range of disposable gloves, aprons and coverings. Antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice. The fittings within the building were modern and compliant with recent guidance relating to healthcare premises.

The practice had a lead for infection prevention control (IPC) who had had specialist training to enable them to provide advice on the practice infection control and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. There had been general audits and audits of individual consulting and treatment rooms. There were notices in the consulting and treatment rooms as to what action to take in the event of a needle stick injury. The cleaning of the practice was carried by specialist contractors who were responsible for cleaning the hospital to which the practice building was attached. There was a schedule of cleaning with different products specified from different purposes. The cleaning was supervised by a member of the hospital staff and checked by the IPC lead.

There was a legionella risk assessment and action had been taken to mitigate the risk.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment (including clinical equipment) was tested, calibrated and maintained regularly and there were equipment maintenance logs and other records that confirmed this.

Staffing and recruitment

The practice had policies and protocols that governed staff recruitment for example, a recruitment policy. These had been reviewed and revised in the light of a recent incident concerning staff records. Personnel records contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records. All relevant staff had Disclosure and Barring Service (DBS) clearance (a criminal records check).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice carried out regular analysis of appointments to help ensure their appointments capacity met patients' requirements. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Records showed that staff were up to date with fire training. There were regular fire evacuation drills carried out in conjunction with the adjacent hospital..

There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied and the door shut to prevent unauthorised access.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records confirmed that all staff were up to date with basic life support training. Emergency equipment was available in the practice, including access to emergency medicines,

Good

Are services safe?

medical oxygen. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The emergency medicines, were in date and reviewed regularly.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. These were comprehensive and gave guidance to staff as to who to contact in the light of different emergencies. The plans had been put into action during a recent breakdown in technology and staff said that they had been very useful.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The practice was commissioned for the new enhanced service designed to prevent unplanned admission to hospital (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Under the new service the practice identified the top two % of the adult practice population with the most complex needs most of whom were older people. These patients had a personalised care management plan and support, tailored to the needs and preferences of the patient and their family. The practice reviewed the information from hospital admissions. The practice acknowledged that it had fallen behind in carrying out this work and had set aside some protected time for staff to catch up.

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

Management, monitoring and improving outcomes for people

There was regular monitoring to assure and improve outcomes for patients. There was some auditing. The practice had carried out an audit of record keeping of minor surgery. This had identified that in some areas the records were inadequate. New checklists were developed and used in the procedures. The second audit had shown a marked improvement in the quality of records.

There had been some prescribing audits carried out in cooperation with the local prescribing advisors and an audit of referrals to secondary care. However the results were not always shared with relevant staff. There was no overall audit plan for the practice. There was no evidence of a structured approach for example, audits aimed at improving care for the practice's larger patient groups. Those audits which had been commenced did not always have follow up or re-audit cycles to show that change, where it had been implemented, had been effective.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice achieved high QOF results and regularly reviewed its QOF outcomes. For example 92 % of patients with a mental health problem had individual care plans and 97 % of these had had their physical health checked in the past year. In the monitoring of the health of asthmatics the practice had reviewed 85 % of those patients in the last year, for young asthmatics (between the ages of 14 and 19) the same figure was 97 %. These two sets of results, mental health and asthma, are above those reported locally and nationally. This was true for most of the other areas where QOF results were reported such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD).

The diagnosis of dementia was the one area where the practice was significantly below the national reported levels. This appeared, at least in part, to be related to how the disease was recorded in the practice records. The issue was replicated across the CCG. In January there had been a review by the CCG of patients' notes to try and validate the accuracy of the information. The results of this were not yet available.

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

The practice had achieved particularly well in the area of child immunisation, percentages of children immunised

Good

Are services effective?

(for example, treatment is effective)

significantly outperformed national levels. In the last year the practice achieved immunisation of 100 % of the target group and in previous years the practice's performance had consistently better than that achieved nationally.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records. There was an overall training plan. Mandatory training such as safeguarding, basic life support and infection prevention control had been completed by all staff. The areas of training that were considered to be most important for the safety of patients and staff had therefore been completed. Staff had completed fire safety training.

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

Both of the nurses were nurse prescribers. This allowed them to prescribe medicines within their clinical competence. One of the nurses was a nurse practitioner. (A nurse practitioner is a nurse who has completed advanced coursework and clinical education beyond that required of the generalist registered nurse). This nurse practitioner saw patients aged 1 year and over (excluding pregnant women), who had new acute problems for example coughs, abdominal pains, urine infection, ear ache, and new musculoskeletal symptoms. This nurse triaged patients for medical treatment, gave telephone advice and made home visits.

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

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. There had been no serious incidents in the previous year resulting from a breakdown in the system. All staff we spoke with understood their roles and felt the system worked well.

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

Information sharing

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

The practice had protocols and systems for referring patients to external services and professionals including acute and medical specialists, social services and community healthcare services. For example, the practice used "choose and book" a national electronic referral service. GPs discussed the referral and choice of hospital with the patient. Staff made the booking on the "choose and book" system and sent a letter to the patient. The patient then confirmed the appointment with the designated hospital.

Good

Are services effective?

(for example, treatment is effective)

Other referrals were by letter. These were dictated or handwritten and typed up by medical secretaries. There had only been one incident where a referral had been missed by the practice but there was no recognised time frame by which the referral ought to completed and no formal system of monitoring this.

Consent to care and treatment

Some GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice.

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded. Consent was specifically recorded for any invasive procedures. Staff we spoke with understood the consent and decision-making requirements of legislation and guidance.

Health promotion and prevention

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

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

During 2012 - 2013 the practice had identified the smoking status of 993 patients over the age of 15 and actively offered nurse-led smoking cessation clinics to 989 of them. This placed the practice in the top 10 % when compared with practices locally and nationally. The practice's performance for cervical smear uptake was 84 %. In 2010 the practice had been in the bottom 10 % of practices nationwide the current performance placed in the top 35 %.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. The last two years' performance for child vaccinations was significantly better than nationally, for example last year the practice achieved a 100 % vaccination rate across the three main child vaccinations. This compared with national figures of between 94 and 97 %. The performance for vaccinations for patients over 65 years and for patients whose condition meant that they were at in increased risk if they caught influenza was in line with the performance nationally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients completed 35 comment cards to tell us what they thought about the practice. Patients thought that the care provided was good and that staff were respectful and considerate. Six comments related to the fact that patients saw different GPs when they went to the practice and that these were in the main locum GPs. This view was corroborated by the GP National survey where only 48 % of patients, completing the questionnaire, said that they got to speak to that GP, this compared with 54 % locally. Eight patients mentioned the difficulty in making appointments but this was at variance with the patient survey where 81% described their experience of making an appointment as good, as opposed to 66 % locally.

A number of questions in the national patient survey and the friends and family test covered the care patients received in the practice. The responses to these questions were all at or above the national averages. For example 77 % of patients felt that GPs treated them with care and concern and that figure rose to 95 % when patients were asked the same question about nursing staff. These results were in line with or above the national average. Ninety four percent describe their overall experience of the practice as good.

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

Incoming telephone calls answered by reception staff and private conversations between patients and reception staff that took place at the reception desk could be overheard by others. However, when discussing patients' treatments staff were careful to keep confidential information private. Staff told us that a private room was available should a patient wish a more private area in which to discuss any issues.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice was rated well in these areas. Data from the national patient survey showed 84 % of practice respondents said the GP gave them enough time, was good at explaining tests and treatment and involved them in care decisions. For nurses the same questions had a response rate of approximately 91 %. Both these results were significantly above average both locally and nationally.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards supported the theme that GPs and nurses gave patients enough time.

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

The practice had access to translation services and there were notices in the reception areas informing patents this service was available. There was a protocol for staff to follow if they needed to engage the services of an interpreter. The practice website could be translated into a range of languages as selected by the user. There was no hearing loop for those with hearing difficulties but the configuration of the reception desk made this impracticable. The practice website could be translated into a number of commonly used languages.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access services such as those related to specific disabilities. Patients we spoke with during the inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

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

When families had suffered bereavement individual GPs decided what level of support was offered. This ranged from no contact to a telephone call to offer support or an appointment if required and signposting the family to other services that could support them in bereavement. There was no common policy or process to help to ensure that any family that needed support would be offered it.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered. For example the practice recognised that because they were located on an island some patients found it difficult to travel off the island to where local services were based. The practice had developed more services in house than might usually be found elsewhere. Services included physiotherapy, psychology, dermatology and ultra sound scanning.

The practice had a patient participation group (PPG). There had only been one meeting of the group during the last year. We spoke with the chair of the group. The chair reported that the practice was very supportive of the group but that it was difficult to get patients interested in attending meetings. There had been a patient survey in October 2014 and the results were discussed with the PPG. Areas where the practice had responded to the PPG included, a review of the information leaflets in the waiting room, changes to the appointments system and more work to inform patients to book double appointments if they have more than one issue to discuss with the GP.

The NHS Friends and family test had been running at the practice since December 2014 and 366 patients had completed the questionnaires. There were positive comments about efficient services and some negative comments about the difficulty in making appointments and in not seeing the same doctor.

Tackling inequity and promoting equality

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

The practice had some learning disability homes within its area. One of the GP had undertaken special training to meet these patients' needs and the patients were booked to see this GP for routine checks. Usually a number of patients with learning disabilities were booked in for routine appointments as a group. This was what these patients said they preferred. It allowed these patients to come to their appointments with their friends which was less unsettling for them. It also caused less abstraction for staff working at the homes and reduced the pressure on them.

Access to the service

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

Primary medical services were provided Monday to Friday from 8am to 6.30pm, the practice was not closed for lunch. There were no extended hours for general surgeries. The practice nurses did have evening appointments for patients who had difficulty in attending during the working day. There were evening clinics for female patients to have reviews of sexual or reproductive health such as fitting of coils and other long-acting reversible contraception methods. The practice was trialling extended hours at another site. It was awaiting the results of the trial before deciding what form of extended hours to use at this site.

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

Longer appointments were available for patients who needed them and those with long-term conditions. There was a range of standard longer appointments. For example patients with a single long-term condition received a 10 minute appointment with a GP and those with more than one problem could book double appointments. Appointments with the practice nurse were for 15 minutes with some exceptions, for example an appointment for a newly diagnosed diabetic patient was for 30 minutes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were generally satisfied with the appointments system. These patients and the comment cards showed that patients felt that they could see a doctor on the same day if they needed to. In surveys 82 % of patients, who responded, said it was easy to get through to the practice on the telephone; the average in the area was 69 %. In the same survey 93 % felt that the reception staff were helpful in making appointments, this compared with 85 % in the locality. As regards the convenience of the appointment 95 % of patients found their appointment convenient as opposed to 90 % for the locality.

Listening and learning from concerns and complaints

There was a complaints policy which included the timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system. There were leaflets in the practice and material on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. However, all felt that if they had to make a complaint they would be listened to and the matter acted upon.

Complaints were received both verbally and in writing. Records showed how complaints had been handled and how the patients had been informed about the outcome. There had been learning from complaints. For example, a patient had complained about the way in which a minor operation had been handled. The practice reviewed the complaint and found that it was justified. Lessons learned from the complaint included; changing the scheduling of some minor operations so there was more time to provide information to the patients and reviewing the patient information leaflets in the practice so that the information that was provided by the practice was more accountable. The lessons were discussed amongst GPs to reduce the chances of the event happening again.

The record showed that patients were involved in discussions, informed about the actions taken and were usually satisfied with the outcome. The minutes of staff meetings also reflected learning from complaints. Complainants were offered an apology where the circumstances warranted it. Complainants were referred to the Health and Parliamentary Ombudsman if the matter could not be resolved and a note of this made on the complaints record.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was published on the practice website. The practice's aim was to offer their patients a wide range of high-quality services targeted to best meet their needs. The staff we spoke understood the practice's aims. Staff told us that they felt well led and described a practice that was open and transparent.

Governance arrangements

Clinical governance was covered in a range of activity. There were policies and procedures that governed activity and guided staff. These were available to staff on the desktop on any computer within the practice. We looked at some of these including a scheme for the control of legionella (a disease found in water systems), training, record keeping, patient safety and incident reporting, infection control, access to medical records, recruitment and induction. There was evidence that staff had read the policies. The policies we looked at were in date and had dates assigned for their review.

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

There were two clinical governance meetings annually. A range of issues was discussed which included prescribing practice, Quality and Outcomes Framework performance, patient safety and serious incidents. The practice learned from incidents, for example measures to improve the processes on recording patient allergies, on sending out referrals for scans and tests and completing records for patients with depression had been discussed and implemented. There was regular e-mail traffic between the GPs which aimed to keep them up to date with, for example, best prescribing practise within the prison regime.

There were regular administrative staff meetings. Lessons learned from incidents were discussed, for example, processes for how patients were booked in for minor operations were changed as a result of an incident and this was discussed at a staff meeting in October 2014.

The practice carried out clinical audit cycles that improved the service and followed up to date best practice guidance. There had been audits on the patient experience with the fitting of coils and implants, an audit of minor surgery and various audits driven by the practice's performance against QOF targets such as audits of the monitoring of patients on high risk medicines. The audits were reactive, usually in response to an incident or patient safety alert. There was no overall audit plan and audits were not planned to address the needs of the more common population groups within the practice.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through a variety of means, including complaints, patients' surveys, the patient participation group and the friends and family test (an NHS wide initiative that provides an opportunity for patients to offer feedback on the services that provide their care and treatment).There was an action plan resulting from this feedback. The main areas for action were; to make more pre-bookable appointments available and to educate patients to ask for extended appointments if they had more than one health issue they needed to discuss. More pre-bookable appointments had been made available. There were notices informing patients about extended appointments and reception staff gave advice to patients if they were unsure whether they needed an extended appointment. However reception staff were careful not to stray into giving clinical advice.

The practice was open to suggestions from staff. For example staff suggested changes to the way some patient's results were received and handled at the practice and the practice adopted them.

Management lead through learning and improvement

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

The practice was accredited for the training of foundation year 2 (FY2) doctors. These are qualified doctors who are seeking a meaningful experience in general practice. As a training practice all the staff were to some degree involved

Are services well-led?

Good

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

in the training of future GPs. The practice was subject to scrutiny by the Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. FY2 doctors were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. GPs' communication and clinical skills were therefore regularly under review