

Dr J K Raval & Partners

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr J K Raval & Partners (Walderslade Village Surgery) on 6 November 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient participation group (PPG), interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all patient population groups.

Our key findings were as follows:

- Patients were very satisfied with how they were treated and this was with compassion, dignity and respect. GPs were good at listening to patients and gave them enough time.

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection. Systems were in place to monitor and make required improvements to the practice.
- Not all patients found it easy to get through on the telephone to book an appointment however, most patients reported they got an appointment when needed.

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?

The practice is rated as good for providing safe care. The practice provided safe and suitable care that protected patients from avoidable harm and abuse. Staff were aware of the policies and procedures for reporting concerns and safeguarding of vulnerable adults and children. Staff had received training in safeguarding children and vulnerable adults. The practice had undertaken an analysis of significant events in the last 12 months where learning points and actions had been recorded. Medicines kept on the premises were stored appropriately and securely. Staff were aware of emergency procedures and knew where the resuscitation equipment was kept.

Good



Are services effective?

The practice is rated as good for providing effective services. The practice had systems to help ensure they could effectively respond to the needs of their patients. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The QOF data for this practice showed that it was performing in line with the national average. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to help ensure continuity of care. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify appraisals and personal development plans for all staff.

Good



Are services caring?

The practice is rated as good for providing caring services. The practice carried out regular satisfaction surveys to capture patients' views. The patients we spoke with and the comments cards we reviewed were very positive about the care patients received. Patients told us that staff were kind, caring and respectful throughout the episode of care that they had received.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and

Good



Summary of findings

meet their needs. There were mechanisms to respond and take action when things did not go as well as expected. There was a complaints process and responses were made in a timely manner. Patients were given the opportunity to make suggestions to improve the services provided, were listened to and actions had been taken to make changes where practicable to do so.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the practice's vision statement and their responsibilities in relation to this. Staff told us they felt supported and that the practice was well-led. There were regular team meetings to help ensure that information was cascaded to all staff team members. This included learning from incidents and any changes to practice across the organisation. There was a complaints policy and procedure as well as a process for escalating incidents to senior managers. All complaints and incidents were reviewed through the clinical meetings. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) were active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

What people who use the service say

During our inspection we spoke with six patients. Patients were complimentary about the care they received and told us that the staff were helpful, knowledgeable and they felt safe and well cared for.

We looked at 18 completed comment cards. The majority of comments we received were positive. Some patients said they had used the practice for a long period of time and they were satisfied with their care. Patients said the staff always did their best and the premises were hygienic and safe.

The practice sought feedback from staff and patients, which it acted on. The practice had a patient participation group (PPG) who they worked with to address concerns from patients. The last practice patient survey in 2013/ 2014 demonstrated that most respondents were satisfied with the practice overall.

Dr J K Raval & Partners

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 and a practice manager specialist advisor.

Background to Dr J K Raval & Partners

Dr J K Raval and Partners (Walderslade Village Surgery) is part of a practice group comprising: Walderslade Village Surgery (Chatham, Kent), Lordswood (Lordswood, Kent) and Balmoral Gardens (Gillingham, Kent). The practice had a list of 8,500 patients and is a training practice.

The practice has five full time partners (four male and one female), two of the partners are GP trainers, four full time salaried GPs (two male and two female) and currently has two GP registrars, who work across all three sites. There are six female nurses, one female healthcare assistant, receptionists, administration staff and a practice manager.

The practice was open from 8.30am until 6pm Monday to Friday with a late evening on Thursday and from 8am until 12noon on alternate Saturdays for pre-booked appointments.

The practice's nursing team work in a similar way to the GPs with their surgery times also having some appointments set aside for emergencies. The practice nurses treat patients affected by minor illnesses and monitor those with chronic diseases. For example, asthma, diabetes, chronic

obstructive pulmonary disease (COPD) and heart disease. The practice nurses' roles include health promotion, wound care, travel and routine vaccinations, cervical smears and ear syringing.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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

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

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the local Healthwatch, Clinical Commissioning Group (CCG) and NHS England to share what they knew. We carried out an announced visit on 6 November 2014. During our visit we spoke with five GPs, the practice manager, four practice nurses three receptionists and six patients who used the service. We reviewed 18 comment cards where patients and members of the public shared their views and experiences of the service. We observed how staff handled calls for repeat prescriptions or appointments.

Are services safe?

Our findings

Safe track record

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments received from patients. Staff we spoke with were able to describe their responsibilities in relation to monitoring, reporting and recording incidents and concerns. They told us they knew the reporting procedures within the practice and were aware of the external authorities that may need to be notified if appropriate.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. The practice also had a serious incident policy. We discussed significant event reporting with the practice manager. They told us staff completed a form and discussed the incident with them. The incident was then discussed at partnership and staff meetings. Minutes of clinical governance meetings demonstrated discussions of significant events were a regular item on the agenda, and subsequent learning points and actions had been taken and recorded. Analysis of significant events had been undertaken. We tracked 12 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example, there had been an incorrect dose of paediatric medicine. Action taken by the practice was that new paediatric medicines were only to be put on the patient's record by a GP. Minutes of meetings demonstrated these learning points were being shared.

Reliable safety systems and processes including safeguarding

A named GP was identified as the safeguarding lead. They had been trained to level three to help them to fulfil this

role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. All patients over the age of 75 years had a named GP.

The practice had policies and procedures for safeguarding vulnerable adults and children which included contact details of the local safeguarding teams. The policy described the types of abuse patient may experience and also gave examples of additional situations that needed careful consideration. There were flow charts and contact numbers for named nurses and GPs who led on child protection, as well as police, social services and local authority designated officers. Contact details were easily accessible.

The practice offered a chaperone option where a member of staff would be available to accompany patients during intimate examinations at their request (or at the instigation of the clinician involved). The practice considered that this was a formal role and mainly nurses or healthcare assistants were allowed to undertake this role and had received the relevant training.

If nursing staff were not available to act as a chaperone, five out of six receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. There were records that documented when a chaperone was present during patient examinations and treatments. There was a risk assessment for reception staff currently working who had undertaken chaperone training (should it be required) who had been with the practice for a period exceeding five years. and at the time of employment Criminal Record (CRB) / Disclosure and Barring Service (DBS) checks were not carried out. However, all new reception staff employed who undertake chaperone training are now DBS checked.

Medicines management

The practice stored vaccines and had medicines for emergency situations. The practice followed guidelines for maintaining the vaccine cold chain so that the viability of vaccinations was assured. Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There were processes for checking that all medicines and vaccines were accounted for. Temperature checks for the refrigerators used to store medicines had been carried out and all medicines and vaccines were stored at the correct

Are services safe?

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

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was training to be an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The premises were clean and tidy. There were cleaning schedules and cleaning records were kept. Antibacterial hand wash, gel and paper towels were available throughout the practice for staff and patients. All instruments were single use only. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The senior practice nurse was the designated lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Infection control audits such as catheter care and hand washing had been carried out.

The practice had an Infection Control policy that outlined the procedures for staff to follow to help ensure that the Code of Practice for the Prevention and Control of Health Care Associated Infections was implemented. The code set out the standards and criteria to guide NHS organisations in planning and implementing infection control measures.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings. We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Nursing staff told us that they had adequate equipment to enable them to carry out diagnostic examinations and treatment. This included equipment and medicines to help ensure that staff were able to provide the appropriate assessment and treatment to patients. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

Records we reviewed contained evidence that the appropriate checks had been completed before staff commenced employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice used one locum GP for consistency and their documents had been validated. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw they had a rota system in place for all the different staffing groups to ensure they had enough staff on duty.

Monitoring safety and responding to risk

The practice had systems to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and the environment. For example, service contracts with specialist contractors in relation to fire safety and electrical testing.

There were processes and meetings to discuss governance issues relating to safety. The practice had developed systems to respond to identified risks. For example, staff we spoke with described the procedure for dealing with safety alerts from outside agencies to keep the practice up-to-date with failures in equipment, processes, procedures and substances.

Are services safe?

Arrangements to deal with emergencies and major incidents

Patients who telephoned the practice when it was closed heard a recorded message that gave them information on how to access out of hours care and advice. The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen however, the practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest,

anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had an emergency plan for winter influenza epidemics and the amount of staffing on the multiple sites allowed for redeployment of staff to fill any gaps. The practice had a plan to deal with potential patients who could be infected with the Ebola virus, which included isolation facilities.

The practice had a business continuity plan. This included all essential elements including loss of site, loss of power, loss of the computer system, staffing and what to do and who to contact in each scenario. However, there was no element to show how the practice would handle an adverse weather situation.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with clearly outlined the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions.

The practice had care plans for complex needs patients and a system for monitoring them in the patient list.

Management, monitoring and improving outcomes for people

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

The practice showed us a clinical audit that had been undertaken in the last year. This audit was conducted following a significant event. The patient had been prescribed oestrogen only hormone replacement therapy (HRT). This error was found during a medication review. This was a completed audit cycle and the practice was able to demonstrate the changes implemented since the initial audit. This resulted in all GPs and nurses being updated on the prescribing of HRT as the nurses were involved in HRT annual reviews.

The practice had systems to help ensure they could effectively respond to the needs of the patients accessing the practice. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The QOF data for this practice showed that it was performing in line with the national average. Information regarding the care received by patients was shared with other healthcare professionals in a timely manner to help ensure continuity of care. Staff referred to guidance from

NICE and used it routinely. Staff had received training appropriate to their roles and any further training needs had been identified and planned. There were records of appraisals and personal development plans for all staff.

Effective staffing

The practice had a recruitment policy for clinical staff. Staff were qualified for their roles. We saw examples of the staff induction training. There was a training matrix that stipulated how often mandatory training was undertaken. Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support, safeguarding, fire and moving and handling.

Through appraisal, there were opportunities for the staff to make their training needs known and the practice also suggested development opportunities for the staff. This formed part of an individual action plan for the following year that tracked individual training and progress.

The GPs we spoke with told us there was some in-house clinical training with lunch time meetings. Administration training was carried out and information cascaded down to appropriate staff. For example, new care plans had been explained so that information could be entered correctly.

Working with colleagues and other services

The practice were involved in local health care planning and had close links with the local clinical commissioning group (CCG), palliative care team and safeguarding children. One of the practice GPs told us that they had a good relationship with the local hospice and that the hospice consultant visited the team on a regular basis. The practice held multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. 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 joint multidisciplinary team meetings with the community matron and district nurses to look at their most vulnerable patients and it planned to continue this with the "Avoiding Unplanned Admissions" local enhanced service (LES). This LES was designed to help

Are services effective?

(for example, treatment is effective)

reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who were at high risk of hospital admission or readmission.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

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.

Consent to care and treatment

The practice had a consent protocol that detailed different types of consent and how to obtain consent, including consent from children under the age of 16 who had sufficient understanding and intelligence to enable them to fully comprehend what was proposed (known as Gillick Competence). For children under 16 (except for those who have Gillick Competence), someone with parental responsibility should give consent on the child's behalf. We were given an example of one patient whose parent did not want them to have vaccinations and the Gillick Competence was used as the child wanted to be vaccinated.

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. We spoke with two members of nursing staff who told us that when a patient attended the practice who may lack capacity they would bring a carer or member

of family with them. We were given an example of a patient who attended for a smear test who was not able to give consent. The nurse did not undertake the procedure and a 'Best Interest Meeting' was set up with the GP.

Health promotion and prevention

There was a range of health promotion and information leaflets available in the practice and on the practice's website.

The practice provided diabetic, weight management, smoking cessation and asthma clinics that were run by the nurses and health care assistants in conjunction with the GPs. Patients were offered smoking cessation advice from the health care assistant. Smoking cessation medicines were prescribed and patients also had the option to access other smoking cessation services.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice including children. The health care assistants undertook 24 hour blood pressure monitoring and electrocardiogram (ECG) tests that record the electrical activity of the heart. They told us that they also ran health check sessions to prevent heart disease, kidney disease and stroke, and invitations were sent out to patients to attend. The practice nurse was the diabetic lead nurse and undertook annual reviews of patients with diabetes. The practice nurse told us that she supported the QOF for diabetes by undertaking audits.

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 who were offered an annual physical health check. Patients identified with mental health problems were managed well.

The practice offered a full range of immunisations for children, travel vaccines and seasonal influenza vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the clinical commissioning group area.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had a dignity and privacy policy. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Patients were able to speak to a receptionist in private in a dedicated room.

The practice had a confidentiality policy and that all staff had signed to show that they had read and understood it. There was a bullying and harassment policy that described disrespectful, discriminatory and abusive behaviour that was unacceptable at the practice.

The practice had a chaperone policy. GPs we spoke with confirmed that chaperones were offered routinely and that this was recorded in the patient's notes. Patients had access to female or male GPs and female nurses if specifically requested, or a different GP if they were embarrassed to discuss something in front of a GP they felt they knew too well.

Care planning and involvement in decisions about care and treatment

The practice had a learning disability register which had recently been updated after liaising with the learning disability team. Patients registered as having learning disabilities were offered an annual physical health check. Patients identified as having mental health problems were managed well.

Patients we spoke to 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 we received was also positive and aligned with these views.

Nursing staff we spoke with told us that before any invasive procedure was undertaken, they informed the patient and gained consent. Nursing staff told us they would not perform any procedure that patients who lacked capacity did not understand. They told us that if they were concerned that a patient did not have capacity to understand proposed care or treatment, they would not perform the procedure. The reason for not performing the procedure would be documented in the patient's notes. Nursing staff told us that in the case of a patient who lacked the capacity to consent, an advocate or carer would be encouraged to accompany them for their appointment. Records demonstrated that staff had received training in the Mental Capacity Act 2005 (MCA2005).

Patient/carers support to cope emotionally with care and treatment

Notices in the patient waiting room told people how to access a number of support groups and organisations. Staff told us that if families had suffered a bereavement, they would be given advice on how to find a support service, for example the local hospice.

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 people's 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.

The practice were involved in local health care planning with the clinical commissioning group (CCG), Community Education Provider Networks (CEPNs), palliative care services, safeguarding children services as well as appraisal and revalidation accreditation to host GPs requiring extra training.

The senior GP partner told us that the practice engaged regularly with the NHS area team and that one of the GP partners was a member of the CCG board. They took lead responsibility for the practice in discussing and reviewing local needs as well as service improvements and priorities for future service developments within the local area.

The practice had extended the nurses' role so that they could treat minor illnesses. The lead nurse was currently undertaking a prescribing course and once completed this was to be rolled out to the other nurses.

Tackling inequity and promoting equality

Staff had access to interpreters via the internet and information in different languages. In addition, there was an agreed policy that the practice would use its own address for anyone that was homeless to ensure they were able to receive appropriate care and support. There was access to a hearing loop for people who had hearing impairment and, if required, the practice contacted a local service for signing for patients with a hearing problem. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The patient participation group (PPG) were trying to improve communication with patients so that they understood how to review the services provided by the practice. The practice's PPG had been involved in scenario testing with staff to give them peer to peer learning and role play opportunities so that staff could learn how to better manage patients that may be unhappy, aggressive

or unable to get what they wanted. The practice had an equality and diversity training policy supplemented by a dignity and emotional support policy. The former was tracked as one of the four areas of practice training records. Records demonstrated that all staff had received Mental Capacity Act (2005) training.

In reception there was an incident report form for reception staff who were asked to record any types of aggressive patient behaviour, physical or verbal. This was then passed to the practice manager who wrote to the patient to advise them that their behaviour had not been acceptable. The patient was also advised that further action may be necessary if there were repeat incidents. Records showed that to date, the practice had not had to take matters further.

Access to the service

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the out-of-hours service was displayed inside and outside the building and included in the patient information booklet. A telephone message informed patients what to do if they telephoned the practice when it was closed.

The practice had a contract with the local walk in centre to take the overflow of acute patients. If patients were referred to the practice by the out-of-hours service, a fax would be received at the practice, reviewed by a named GP and appropriate action taken.

The GPs we spoke with told us that referrals were made on digital dictation. They told us that Choose and Book (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) was made by a secretary, unless, patients insisted on the day of their appointment that the booking be made.

The practice offered extended hours. The practice was open from 8.30am until 6pm Monday to Friday with a late evening on Thursday and from 8am until 12noon on alternate Saturdays for pre-booked appointments only. This was primarily for patients who found it difficult to attend during working hours.

We spoke with three patients before the surgery opened. They reported not being able to get through on the telephone, not being seen soon enough or not being seen on the same day if it is urgent. The GPs were aware that

Are services responsive to people's needs?

(for example, to feedback?)

access to appointments was a problem at this practice even though the evidence suggested they were offering 30 more appointments per month than they were required to. The practice looked at appointments and benchmarked themselves against other practices. Their practice population required the provision of 1,050 appointments per month and they offered 1,080.

Reception staff were trained to recognise patients with urgent problems and they slotted these patients in with a nurse or GP. The practice had plans to continue working on access to appointments including training receptionists on the Royal College of General Practitioners (RCGP) toolkit for receptionist triage. This would better utilise the nurses' time by taking cases that were currently being passed through to doctors. The practice also implemented a system where the receptionist passed all home visit requests to a nurse so that a clinician made the decision of whether a home visit was necessary.

The practice planned to implement minor illness surgeries from January 2015 which would roll out with the RCGP triage for receptionists, to help direct patients to the right GP or nurse first time. The duty GP was overwhelmed by all types of requests, and this would help to make their workload more manageable and expedite patient care.

Listening and learning from concerns and complaints

The practice had a complaints policy that adhered to NHS guidelines. It described the timescales for response, the time limits to complain, the name of the designated GP, the right of appeal and further action patients could take if not satisfied through the Patient Advice and Liaison Service (PALS) and the Parliamentary and Health Service Ombudsmen. The designated GP who handled all complaints in the practice, drafted replies and met complainants if necessary. Some complaints were on the practice website and were anonymous. The practice responded to these complaints by posting an invitation on the website for the patient to visit the practice to discuss the problem.

The practice had a complaint form advising patients how to complain, what to do for a complaint being made on behalf of someone else, what the practice would do regarding an initial response (three working days) and a resolution date (10 working days).

The practice had reviewed complaints on an annual basis to detect themes or trends. In the last year the practice had received 15 written complaints and three verbal complaints. Patients were able to give feedback through complaints, verbally, via a suggestion box and on the NHS choices website. The practice had responded to comments on the NHS choices website.

Are services well-led?

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

Our findings

Vision and strategy

The practice philosophy and strategy was built by the partners and practice manager at an away day in January 2014. The practice vision and values included offering a friendly, caring good quality service that was accessible to all patients.

Nurses met with the lead nurse, and receptionists met with the lead receptionist to feed in their ideas into the strategy meeting in advance to help ensure that staff at all levels had been represented.

Strategy meetings were held quarterly and there were fortnightly business meetings where actions from the previous meeting were reviewed. We were told that this generally tended to be a GP and the practice manager forming the strategy and that there were team days, where the nurses and administration staff could put their thoughts forward for the discussion.

There were different partners responsible for certain areas of management within the practice. For example, finance and business, Quality and Outcomes Framework (QOF) monitoring, data entry, complaints monitoring, governance, management and protocols.

We spoke with the nurses who told us they met once a week and that the practice manager attended these meetings who used them as a way of updating the nurses on the weekly management team meetings. The nurses also attended the clinical meetings where they met together with speakers who were local consultants or one of the partners.

Governance arrangement

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 11 of these policies and procedures and saw they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, a named GP was identified as the safeguarding lead and when we spoke with them they understood their role and responsibilities. The practice nurse was the infection control lead. We spoke

with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The practice had annual meetings to look at the quality indicators and how they were mapped, QOF and patient survey.

Minutes of staff meetings demonstrated that risk was a topic on the rolling agenda. The practice had a well written and robust risk management policy which included the risk management matrices. However, there was no record of the policy being shared with staff and it was not reflected in the personnel files that we reviewed.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, medicines review audits that were discussed at medicines management meetings.

The practice had a well written and robust risk management policy which included the risk management matrices. We looked at the minutes of staff meetings. We saw that the risk management matrices were regularly discussed at team meetings and was a topic on the rolling agenda.

Leadership, openness and transparency

The practice staff appeared to have a very informal and open forum. It was evident they were comfortable and confident in the company of each other. There were weekly, quarterly and annual meetings that included staff at all levels. When we spoke with staff they told us they could talk to anyone at any time and felt that they would be listened to.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and protocols, such as disciplinary procedures, the induction policy and management of sickness which supported staff. A staff handbook was available to all staff, which included sections on equality as well as harassment and bullying at work.

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

The practice proactively sought feedback from staff and patients, which it acted on. The practice had undertaken an

Are services well-led?

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

annual staff survey in 2014 however, the results had not yet to be analysed. The 2013 staff survey asked reception staff specifically for their ideas on how to improve patient access. The staff were given a list of options to choose from and could submit the survey anonymously if they wished. Some of the ideas had been implemented such as the telephone triage and other ideas were still in the planning stage, for example training reception staff with the Royal College of General Practitioners (RCGP) toolkit, in order that they could allocate patients to the right GP or nurse at the right time.

The practice had a patient participation group (PPG) who they worked with to address concerns from patients. The last practice patient survey in 2013/ 2014 demonstrated that most respondents were satisfied with the practice overall. The PPG were active. The practice listened to the PPG, public and staff and tried to learn from them and make appropriate changes. We spoke with two members of the PPG who told us they had good meetings with the GPs who were really trying to improve services. They told us that at one of the meetings they had suggested extending practice hours. The practice had subsequently extended their hours on a Thursday evening and alternate Saturday mornings. The PPG also prompted the change to the telephone number from 0844 to 01634 in line with the local area dialling code.

Management lead through learning and improvement

The practice had an annual staff appraisal policy and procedure document describing what was to take place before an appraisal, during and follow up actions. There was an appraisal planning document for all of the staff, including the time and date of the appraisal and who would conduct it. There were appraisal action plan tracking documents going back to 2012 showing what actions needed to take place. Nurses appraisals were carried out by a designated GP. GP appraisals were carried out by mentors as part of their continuing professional development (CPD). Records substantiated this.

The practice was a training practice and all the GPs and nurses were to some degree involved in the training of future GPs. The quality of GP decisions was therefore often under review. In addition the practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (formerly called the Deanery). Trainee GPs were encouraged to provide feedback on the quality of their placement to Health Education Kent, Surrey and Sussex and this in turn was passed to the GP practice.

We spoke with one of the GP registrars who praised the practice. They felt that they were being taught well at the practice. They felt well supported and told us they were always given a debrief at the end of the day. The registrars told us they felt that the practice was safe, effective, caring, responsive, well led and had they no concerns.