Kingsnorth Medical Practice

Quality Report

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Date of inspection visit: 17 November 2016
Date of publication: 13/04/2017

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kingsnorth Medical Practice on 17 November 2016. Overall the practice is rated as outstanding.

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

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- A proactive approach to anticipating and managing risks to people who use services was embedded and was recognised as the responsibility of all staff.
- There was an open and transparent approach to safety and an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise safeguarding concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Staff were committed to working collaboratively and people who had complex needs were supported to receive coordinated care. There were innovative, proactive and efficient ways to deliver more joined-up care to people who used services. For example, the introduction of the Community Practitioner and the weight management programme.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Feedback from patients about their care was consistently positive.

Summary of findings

- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent and non-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.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw several examples of outstanding practice:

- The practice offered an extensive range of additional services, providing secondary care closer to home, achieving significant auditable results, benefits and improved outcomes for patients. It reached out to the community and worked in close and constructive partnership with local hospital consultants. Services included a full muscular skeletal service, Cardiology, Ear, Nose and Throat, (including Paediatrics) and Vasectomy. In January 2017, Orthopaedic outpatient clinics were also introduced. The practice ethos of delivering care closer to home had achieved a lower rate of referrals to secondary care. The rate achieved was 41 per 1,000 patients compared to the CCG average of 52 per 1,000 patients. The practice also offered a minor injury service, which was available to registered and non-registered patients. This service had resulted in the practice achieving the second lowest rate within the CCG area for children up to 17 years attending accident and emergency due to injury. The practice worked closely with its Patient Participation Group (PPG) to promote the services offered. It ensured that local schools, sports clubs and children's clubs were made aware of the minor injuries and other services. They also advertised on community notice boards.

The areas where the provider should make improvement are:

- Ensure that minutes and records of investigations into complaints and significant events are fully auditable and provide accountability.

Professor Steve Field CBE FRCP FFPH FRCGPChief 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.

- There was a system for reporting and recording significant events, however some records were limited in detail and did not always fully evidence the investigative activity and action that had been taken, and how the lessons that had been learned were disseminated.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed and we saw that a proactive approach to anticipating and managing risks to people who uses the services was embedded and recognised as the responsibility of all staff.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were consistently at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Performance monitoring evidenced high achievement within the clinical commissioning group (CCG) area.
- The practice ethos of delivering care closer to home had achieved a lower rate of referrals to secondary care. The rate achieved was 41 per 1,000 patients compared to the CCG average of 52 per 1,000 patients.
- Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so.
- With the introduction of the role of Community Practitioner the practice had been proactive in its approach to the delivery of high quality care in collaboration with other organisations to improve the health and well-being of its patients.

Summary of findings

- A member of the practice team had developed and offered an adult obesity programme which had been recognised at the Health Care Support Worker (HCSW) awards in 2014 for outstanding contribution to general practice and patient care. An audit of 10 patients that were referred to the programme showed a cumulative weight loss of 77 kilograms.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked in partnership with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed 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 for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. Three GP partners and the practice manager held key roles within the CCG group. A GP partner held the role of Chair of the Ashford Federation and the practice manager chaired the local practice managers group. The practice also engaged with the medicines optimisation team.

- Patients said they were able to make an appointment with a named GP and there was continuity of care, with all requests for appointment being triaged by a GP on the day of request, prioritised and further managed by way of telephone consultation, same day or next earliest appointment.

Summary of findings

- The practice recognised the benefits of being proactive in supporting the health and well-being of its older population. It offered innovative, proactive and personalised care and had introduced the role of Community Practitioner.
- The practice had good facilities and was well equipped to treat patients and meet their needs. It offered a minor injuries service which provided care closer to patients' homes and reduced the burden on hospital services. This service was open to people registered elsewhere. It had achieved the lowest rate within the CCG area for children up to 17 years attending accident and emergency and the fourth lowest rate for all patients over the age of 18 years.
- Data for 2011 to 2014 showed that the practice had achieved low rates of hospital admission due to its holistic approach to patients.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people.

- Whilst the percentage of the patient population that fell within this population group was four percent of the total, the practice viewed this group as often experiencing complex health needs and at a higher risk of an unplanned hospital admission. They recognised the benefits of being proactive in supporting the maintenance of health and well-being and offered innovative, proactive and personalised care to meet the needs of the older people in its population
- The practice demonstrated a holistic approach to the care of its older patients with a focus on care being delivered nearer to home and maintaining continuity. The introduction of the Community Practitioner and the positive partnership they had built with their patients had led to the practice achieving the lowest rate of referral to the district nursing service within the locality.
- The practice was responsive to the needs of older people, and offered home visits and extended appointments for those with enhanced needs. The Community Practitioner allocated the time needed to effectively manage each patients concerns and liaised with other care providers, statutory bodies to ensure appropriate care planning and support was put in place.
- The practice identified all of its older patient's population and contacted every patient who had not been seen for over a year to check on their health and welfare.
- All staff had received training in safeguarding adults to the appropriate level and we saw evidence that procedures were effective and well-managed.

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People with long term conditions

Outstanding ☆

The practice is rated as outstanding 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.

Summary of findings

- The practice managed a register of patients who were identified as being at risk of developing diabetes and those patients were screened on an annual basis and supported to reduce the risk by providing appropriate lifestyle advice.
- Where practicable and in support of those patients who worked or who had young families, flexibility was provided around appointments and routine tests. They were arranged at a convenient time for the patient followed by a telephone consultation with the GP.
- The practice also proactively screened patients who attended for flu vaccination and who were identified as being at risk of atrial fibrillation (an abnormal heart rhythm). This had resulted in the practice achieving the highest detection rate within the clinical commissioning group (CCG) area. Early detection and treatment of atrial fibrillation was a factor in reducing the risk of those patients suffering a stroke.
- Patients with long-term conditions were recognised as being at an increased risk of depression and annual reviews included screening for depressive symptoms.
- Patients with long-term/complex conditions were triaged to establish and allocate the appropriate length of time needed to assess and review all current and on-going problems, care and treatment. This facilitated continuity of care in a single consultation and avoided the need for multiple appointments.
- Flu vaccinations rates for patients suffering from long-term conditions were consistently higher than local and national averages. For example: The percentage of patients diagnosed with diabetes who had received the flu vaccination in the year 2015/2016 was 98%, which was five percent above the clinical commissioning group (CCG) and four percent above the national averages. In 2014/2015 the practice rate was 96%, four percent above the CCG and three percent above the national averages. In 2013/2014 the practice rate was 96% which was two percent above the CCG and three percent above the national averages.
- The percentage of patients diagnosed with Stroke or Trans-ischaemic attack who had received the flu vaccination in the year 2015/2016 was 95%, five percent above the CCG and one percent above the national averages. In 2014/2015 the practice rate was 97%, seven percent above the CCG and three percent above the national averages. In 2013/2014 the practice rate was 97%, three percent above the CCG and three percent above the national averages.
- Patients unable to attend the surgery were assessed and reviewed by the community practitioner in consultation with their named GP.

Summary of findings

- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 90% compared to the Clinical Commissioning Group average of 85% and the national average of 88%.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people.

- The practice ensured they registered whole families living at the same address to ensure a full picture was available to clinicians.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example: children and young people who had a high number of A&E attendances. The practice held multidisciplinary healthcare meetings for this purpose, with outside agencies in attendance.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice routinely sent congratulatory cards to parents following the birth of a child, with appointment invitations. The practice offered a system of one appointment to conduct the mother's post-natal check, a baby health check and baby immunisations.
- The practice identified that many of the transient commuting population had minimal family and support networks and proactively screened new mothers for symptoms of post-natal depression.
- The practice was proactive in contacting patients and reminding them to attend screening. The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding 5 years was better than local and national averages at 91% compared to the clinical commissioning group(CCG) average of 82% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered protected drop-in appointments after school/work targeted at young people to allow greater and

Summary of findings

more flexible access to the service. This has been of particular benefit when patients have wanted to discuss sensitive issues such as emergency contraception, emotional/sexual or other health advice.
- The practice achieved the highest percentage within the CCG area, of children aged two, three and four vaccinated against flu. Non-attenders were contacted and encouraged to attend. The practice made good use of text reminders.
- We saw positive examples of joint working with midwives and health visitors and the practice met with them on a bi-monthly basis. The midwife held weekly clinics at the practice affording staff the opportunity for regular liaison.
- The practice offered minor injury appointments and had achieved the lowest rate within the CCG area for children up to 17 years attending accident and emergency.
- Staff were all trained in safeguarding children to the appropriate level and we saw evidence that safeguarding procedures were effective and well-managed.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered telephone consultations and text reminders. These were used to good effect in conjunction with a variety of tests used to monitor long-term conditions. Patients were provided with relevant equipment and guidance to support self-care where appropriate.
- The practice offered over 40 health checks screening blood pressure, cholesterol and blood sugar levels.
- The practice offered two Saturday flu vaccination clinics each October for working patients and carers. Blood pressure checks were also offered at these clinics to maintain essential health monitoring for relevant patients.
- Vasectomy clinics were held on a monthly basis on a Saturday morning to support working age men and their families.

Summary of findings

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

- The practice made use of flags on the computer system to highlight patients living in vulnerable circumstances including homeless people, unaccompanied children/asylum seekers, those with language barriers, hearing/speech/vision impairment and those with a learning disability. This enabled the practice to provide tailor-made access to care.
- The practice recognised the value of the reception team in identifying vulnerable patients through their interactions and observations, and reporting concerns was proactively encouraged.
- Any notification that a patient had self-harmed/overdosed was referred to the duty doctor as a priority. Following assessment, the patient would, where possible, be contacted and the patients named GP would be tasked to follow the incident up.
- The practice maintained a register of patients identified as being vulnerable. The practice lead for safeguarding reviewed the care of these patients at the point of registration.
- The practice offered longer appointments for patients with a learning disability. It had a nominated champion for learning disabilities who was available to be present during GP consultations in the practice or the home environment at a time which best met the patient's individual needs.
- Vulnerable patients' booked appointments were flagged so that any cancellation by the patient would result in the clinician being alerted and follow up with a telephone call to that patient. The Practice limited the use of the text reminder system so that appointments could not be cancelled automatically. This review of cancellation requests supported the safeguarding of vulnerable patients.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

- 87% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, (with four exceptions equalling10%), which was better than the clinical commissioning group (CCG) average of 82%, (exception rate of 10%),and the national average of 84% (exception rate of 8%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 95% (with eight exceptions equalling16%),compared to the CCG average of 86% (exception rate of 10%, and the national average of 88%, (exception rate of 13%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice was proactive in identifying poor mental health and intervening at an early stage.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia and many, including non-clinical staff, had received training. All dementia patients received telephone reminders from the reception team on the day of an appointment.
- The community nurse practitioner conducted home visits for dementia patients to undertake medicine reviews and check that medicines was being taken as prescribed and look for potential signs of medicine hoarding.
- The nurse practitioner used the dementia register to arrange for flu, shingles and pneumonia vaccinations.
- The practice achieved the highest rate of dementia diagnosis due to its proactive approach within the older patient population.
- The practice provided accommodation for the mental health team to see patients, including those not registered at the practice.
- The practice operated a safeguarding measure for patients identified as being at high-risk and any cancellation of an appointment by them was referred to the relevant GP and proactively followed up.

Summary of findings

- All patients who had attempted self-harm were discussed at the monthly multidisciplinary team meeting.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above local and national averages, 256 survey forms were distributed and 121 were returned. This represented 1% of the practice's patient list.

- 95% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

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

We received 30 comment cards which were all positive about the standard of care received. Patients described staff as being caring, professional, kind, friendly, helpful and polite. They stated that they were treated with dignity and respect, felt listened to and were never rushed.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. We saw written evidence of requests from patients to remain registered at the practice following a move out of the practice catchment area. The practice also sought feedback via the friends and families test. Comment cards submitted between 9 November 2015 and 3 November 2016 showed that 94% of respondents said that they would recommend the practice, four percent stated that they would not recommend the practice and two percent were unsure.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that minutes and records of investigations into complaints and significant events are fully auditable and provide accountability.

Outstanding practice

- The practice offered an extensive range of additional services, providing secondary care closer to home, achieving significant auditable results, benefits and improved outcomes for patients. It reached out to the community and worked in close and constructive partnership with local hospital consultants. Services included a full muscular skeletal service, Cardiology, Ear, Nose and Throat, (including Paediatrics) and Vasectomy. In January 2017, Orthopaedic outpatient clinics were also introduced. The practice ethos of delivering care closer to home had achieved a lower rate of referrals to secondary care. of delivering care closer to home had achieved a lower rate of referrals to secondary care. The rate achieved was 41 per 1,000 patients compared to the CCG average of 52 per 1,000 patients. The practice also offered a minor injury service, which was available to registered and non-registered patients. This service had resulted in the practice achieving the second lowest rate within the CCG area for children up to 17 years attending accident and emergency due to injury. The practice worked closely with its Patient Participation Group

Summary of findings

(PPG) to promote the services offered. It ensured that local schools, sports clubs and children's clubs were made aware of the minor injuries and other services. They also advertised on community notice boards.

Kingsnorth Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Kingsnorth Medical Practice

Kingsnorth Medical Practice is situated in Kingsnorth, Ashford, Kent and has a registered patient population of approximately 11,157. The practices catchment largely covers new town residential areas with a high ratio of commuting population and young families. The patient population is also transient with an average of 1,350 patients leaving and 1,349 registering with the practice for the years 2014 to 2015 and 2015 to 2016. Eighty nine percent of the population are under the age of 65, with 47% under the age of 18. Eleven percent of the population are over the age of 65.

The practice staff consist of four GP partners (male) and four salaried GPs (female), one GP registrar (female), one community nurse practitioner (male), four practice nurses (female), three healthcare assistants (female), one phlebotomist (female), one practice manager, one deputy practice manager as well as administration and reception staff. Patient areas are on the ground and first floors with waiting rooms in both areas. CCTV cameras allow the reception team to monitor patient safety in the first floor waiting area. A lift provides access to the first floor and all areas are accessible to patients with mobility issues as well as parents with children and babies.

The practice is a teaching and training practice (teaching practices have medical students and training practice have GP trainees and newly qualified doctors).

The practice has a personal medical services contract with NHS England for delivering primary care services to the local community.

Services are provided from Ashford Road, Ashford, Kent, TN23 3ED.

Kingsnorth Medical Practice is open Monday to Friday between the hours of 8am to 6.30pm. Appointments are available from 8.00 am to 6.30 pm Monday to Friday.

There are a range of clinics for all age groups as well as availability of specialist nursing treatment and support.

There are arrangements with other providers (Primecare) via the NHS 111 system to deliver services to patients outside of the practice's working hours.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 November 2016. During our visit we:

- Spoke with a range of staff including four GPs, two nurses (including the community practitioner), non-clinical staff and the practice manager. We also spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. Whilst the practice incident recording form did not specifically refer to the duty of candour, we saw and heard evidence that the practice complied with this requirement. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. However, some records were brief and did not always fully evidence the action that had been taken and the method and date when lessons learned were disseminated.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were learned and relevant action identified to improve safety in the practice. For example, a patient received a vaccination in error. The clinician correctly reported the matter, sought advice regarding potential risks to the patient, informed and reassured the patient and apologised. The matter was discussed with the clinical team. A written apology was also sent to the patient and all clinicians were reminded of the importance of checking immunisation history and the clinician concerned revised their procedure for checking patient records prior to vaccination.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- There were arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- The practice held a 'cause for concern' register of patients who were not engaged with social care but where milder concerns about care needs had been raised. Their names/families were highlighted to Health Visitors, School nurses and Midwives prior to safeguarding meetings so that any similar mild concerns/information could be identified and shared at the meeting. This multi-agency process of information sharing resulted in early intervention and onward social care referrals.
- Any request for information from the social services in relation to a patient under the Children Act 1989 (sections 17, 27, 47), was added to the cause for concern register until the outcome of those enquiries was known.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who had recently attended training to undertake this role and was therefore up to date with best and current practice. There was an infection control protocol in place and staff had received training. The practice had made a number of changes to support the infection control protocol. This included replacing fabric curtains in clinical rooms with disposable curtains and replacing all the chairs in the clinical rooms with those that were wipe clean.

Good

Are services safe?

- We saw evidence that new wipe-clean flooring had been planned for all GP consulting rooms. We also saw evidence that an annual infection control statement had been produced and that an infection control audit had been undertaken. No additional improvements had been identified, However, there were fixed metal bins in the toilets for the disposal of hand towels which showed signs of rusting. This was raised with the practice, promptly managed and evidence of the purchase of new bins has been received.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The GPs operated a buddy system to ensure cover was maintained. Leave was planned on an annual basis with dates being rotated to ensure popular holiday periods were allocated fairly. Part-time staff supported their colleagues by volunteering for additional shifts at peak holiday periods and to cover staff sickness.

Arrangements to deal with emergencies and major incidents

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

- We saw evidence that the practice team had responded and provided medical care at a serious road traffic collision that occurred near to the practice.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. The Community Practitioner also carried a defibrillator and portable oxygen for use as necessary during home visits.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of the plan was kept off-site.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results were 100% of the total number of points available. The combined overall average of the exception rate for the practice was 10% compared to the clinical commissioning group(CCG) average of 8% and the national average of 9%.

QOF figures for 2014/2015 and 2015/2016 showed that the practice performed between 1and 9% higher than CCG and national averages. This was of note in a practice where the patient population was transient with an average of 1,350 patients leaving and 1,349 registering with the practice for the years 2014/2015 and 2015/2016.

Of note was the practices performance in relation to the percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months. In the QOF year 2014/2015 the practice rate was 87% compared to the CCG average of 82% and the national average of 84%. In the QOF year 2015/2016 the practice rate was 95% (with no exceptions), compared to the CCG average of 79% and the national average of 83%. The practices performance in this area had improved substantially against CCG and national averages.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 1 April 2014 to 31 March 2015 showed:

Performance for diabetes related indicators was similar to local and national averages.

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months was 84% (with 51 exceptions equalling 12%), compared to the CCG average of 80% (exception rate of 11%), and the national average of 78%, (exception rate of 12%).
- The percentage of patients with diabetes, on the register, who had had influenza immunisation in the preceding 1 August to 31 March was 96% (with 69 exceptions equalling 17%), compared to the CCG average of 92%, (exception rate of 16%), and the national average of 94% (exception rate of 18%).
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 88% (with 48 exceptions equalling 12%), compared to the CCG average of 79% (exception rate of 11%), and the national average of 81% (exception rate of 12%).

Performance for mental health related indicators was similar to local and national averages.

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 95% (with eight exceptions equalling 16%), compared to the CCG average of 86% (exception rate of 10%), and the national average of 88% (exception rate of 13%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 87% (with four exceptions equalling 10%), compared to the CCG average of 82% (exception rate of 10%), and the national average of 84% (exception rate of 8%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 93% (with seven exceptions equalling 14%), compared to the CCG average of 88% (exception rate of 8%), and the national average of 90% (exception rate of 10%).

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Performance monitoring evidenced high achievement within the clinical commissioning group (CCG) area.

- The practice achieved the highest uptake of flu vaccination in the persons at risk group.
- The practice achieved the highest rate of flu vaccination in the over 65 group.
- The practice achieved the lowest rate of prescribing Cephalosporin's
- The practice achieved the highest rate of dementia diagnosis due to its proactive approach within the older patient population.
- The practice proactively reached out to the community and working constructively with other organisations to improve patient outcomes. The practice offered minor injury appointments and had achieved the second lowest rate within the CCG area for children up to 17 years attending accident and emergency due to injury. The minor injuries service was set up following discussions with the Clinical Commissioning Group (CCG) and the local Accident and Emergency (A&E) service. The aim was to reduce pressure on the local A&E. The practice Patient Participation Group (PPG) was consulted. To promote the new service, the PPG ensured that local schools, sports clubs and children's clubs were made aware of the service and its limitations. They also advertised on community notice boards. The service has proved to be a success which is clearly shown in performance data.
- The practice delivered a high quality, additional service which has benefitted patients. The introduction of the Community Practitioner and the minor injuries capability resulted in the practice achieving the lowest rate of referral to the district nursing service within the locality. The practice achieved a referral rate of 42 per 1,000 population. The highest rate was 121 per 1,000 population.

The practice told us that their model of management and care had resulted in a higher ratio of clinicians to patients, care being delivered at or closer to home, continuity and additional time to manage the emotional and physical well-being of the most vulnerable patients.

Staff were consistent in supporting people to live healthier lives through a targeted and

proactive approach to health promotion and prevention of ill-health, and every contact with people was seen as an opportunity to do so. We saw evidence that the practice was proactive in its approach to delivering high quality care in collaboration with other organisations/health-care providers where appropriate, to improve the health and well-being of its patients. For example: The practice was proactive in the prevention of diabetes mellitus. It identified and monitored patients at risk of developing this condition, provided lifestyle advice and where relevant, a 15 week weight-loss programme. The practice audited the progress of 10 patients who were signposted to the programme by clinicians. A cumulative weight loss of 77 kilograms had been achieved.

The practice was proactive in identifying patients at risk from a number of long-term conditions. Public Health England data showed that it achieved the highest rate within the CCG area of new diagnosis of depression during 2014 to 2015 due to its focus on early identification of at risk patients. One example was the screening of all new mothers to identify anyone at risk of or suffering from post-natal depression. Another example was the routine screening for depression of all patients with long-term conditions as part of their annual review as it had been recognised that they had an increased risk. Patients with a learning disability were also screened on an annual basis.

It also proactively screened patients who attended for flu vaccination and who were identified as being at risk of atrial fibrillation (an abnormal heart rhythm). Public Health England data showed that this had resulted in the practice achieving the highest rate within the CCG area of detection of Atrial Fibrillation during the period 2013 to 2014. The practice rate was 106% compared to the lowest rate of 50%.This resulted in prompt treatment.

There was evidence of quality improvement including clinical audit.

There had been 10 clinical audits undertaken in the last 12 months, four of these were completed audits where the improvements made were implemented and monitored.

Findings were used by the practice to improve services. For example, recent actions taken as a result included changes implemented to improve the percentage of post vasectomy sample submissions. An audit identified that between July 2014 and December 2014 the percentage of patients that had submitted the required two post-operative samples was 47% of the 53 patients meeting the criteria for inclusion. The practice enhanced their preoperative

counselling procedures, provided more information to patients fully explaining the importance of submitting post-operative samples, implemented and analysed feedback questionnaires and extended the timescales for submissions. A second audit identified that between July 2015 and December 2015 the percentage of patients that had submitted the required two samples had risen to 58% of the 73 patients meeting the criteria for inclusion. This was an improvement of 11%. In all cases where post-operative analysis had been completed the failure rate was zero.

The practice held a comprehensive audit plan and tracker. We saw evidence that audit was performance and patient need driven. For example: The practice audited patients who were treated at the practice under the muscular-skeletal services between 2012-2014. This single audit concluded that 586 patients had been treated locally who would otherwise have been referred to secondary care. The practice also audited patients who were treated at the practice under ear, nose and throat (ENT) services between 2015-2016. This single audit concluded that 138 patients had been treated locally who would otherwise have been referred to secondary care. These patients were benefited by being able to be treated locally. Further audits have been planned to continue to monitor success in this area.

Effective staffing

Staff had the skills, knowledge and/or experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as, fire safety, health and safety, emergency procedures, waste handling, dress code, practice policies and procedures, staff handbook, confidentiality and disciplinary procedures.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice held a comprehensive training tracker/ schedule which demonstrated the wide variety of training that had been undertaken by staff. For example: Innovation for pre-hospital emergency care, conflict resolution, female genital mutilation, forefoot deformities, the law relating to sexual activity, preparing witness statements for crown court, managing an unexpected outbreak of infectious disease in a school environment, cow milk allergy and the home office prevent strategy (addressing hate crime and radicalisation).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice ethos of delivering care closer to home had achieved a lower rate of referrals to secondary care. The rate achieved was 41 per 1,000 patients compared to the CCG average of 52 per 1,000 patients.
- The practice shared relevant information with other services and agencies in a timely and appropriate way, for example when making referrals.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients

moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and the practice nursing team provided lifestyle advice and support for this purpose. Patients were also signposted to additional support services where appropriate.

The practice's uptake for the cervical screening programme was 91%, which was better than the CCG average of 82% and the national average of 82%. The practice's uptake for the cervical screening programme was consistently better that CCG and national averages and between four to ten percent higher for the past eleven years. There was a policy to remind patients who did not attend for their cervical screening test. The practice demonstrated that they also actively encouraged uptake of national screening programmes for bowel and breast cancer screening. There were systems to ensure results were received for all samples sent for the cervical screening programme which also followed up women who were referred as a result of abnormal results.

It developed an innovative service which promotes patient self-management, is popular with patients and demonstrates improved outcomes. A member of the practice team had developed and offered an adult obesity programme which had been recognised at the Health Care Support Worker (HCSW) awards in 2014 and won the award for outstanding contribution to general practice and patient care.

Childhood immunisation rates for the vaccinations given were comparable to the CCG averages. The data for the practice was obtained directly from the practices computer system and confirmed by NHS England and Public Health England). This method was used due to a gap in the data available at the time of the inspection. Confirmed childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 98% (data confirmed by NHS England and Public Health England) compared to the CCG average of 86% to 96% and five year olds at 93% compared to the CCG average 90% to 97%.

In one area of childhood immunisation, the practice achieved the highest percentage within the CCG area. This achievement was in relation to children aged two, three and four being vaccinated against flu. Non-attenders were contacted and encouraged to attend. The practice made good use of text reminders.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 30 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with Three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 86% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 92%% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read large print format.
- We saw information in reception that there was a hearing loop.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 146 patients as carers (1% of the practice list).

The practice had appointed the Community Practitioner as a lead for carers (carers champion). The practice had a well maintained carers register. The Community Practitioner sent a letter to all patients on the register to offer their services as a point of contact and support. It was recognised that there were likely to be many carers acting in an unpaid caring role for disabled friends and relatives that may not stop to consider their own health and wellbeing. The letter fully explained the service that the Community Practitioner provided. The practice told us that it had received positive verbal feedback from those patients in relation to this service. The Community Practitioner also wrote for the purpose of establishing each carers current caring commitment and support needed.

The Community Practitioner was able to offer carers flexible appointments and home visits where necessary and appropriate. Written information was available to direct carers to the various avenues of support available to them. The practice was proactive in identifying patients who had caring responsibilities and the practices new patient registration forms contained a section asking patients if they had caring responsibilities.

Staff had a good understanding of how to support patients with mental health needs and dementia and many, including non-clinical staff, had received training. All dementia patients received telephone reminders from the reception team on the day of an appointment.

Staff told us that if families had suffered bereavement, the death was noted on the list for the duty doctor and a message was sent to all staff members and a condolence letter sent to the next of kin. The relevant GP would make contact with the family. Followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning croup (CCG) to secure improvements to services where these were identified. The practice was very active in its involvement with the CCG. Three GP partners and the practice manager held key roles within it. The practice was also very active in its involvement with the Federation, Ashford Clinical Providers whereby one GP partner was the chair and the practice manager chaired the local practice managers group.

- The practice had five GPs with special interests (GPwSI). This was in line with the strategy of bringing care closer to home. The GPwSIs were a resource across the locality and patients from other practices could be referred to them. The practice told us that the use of GPwSIs reduced delays, improved access and delivered care closer to home for all patients in the area. The areas covered were; Cardiology, Ear Nose and Throat (ENT), Gynaecology, Muscular-skeletal services (MSK) and Vasectomy.
- The practice hosted consultant led outpatient's clinics for Paediatric ENT and Gynaecology. The practice has told us that in January 2017, Orthopaedic outpatient clinics were also introduced. These clinics were integrated with secondary care and some were offered on Saturdays. Where the referring GP was a GPwSI in the area concerned this led to enhanced initial assessment of the patient with all relevant tests and scans having been conducted. It also led to improved communication with secondary care. With both primary and initial secondary care being held at the practice the consultant had access to the GP patients' records and a more holistic approach was applied to the care being delivered.
- The practice had four practice nurses trained in special interest areas. These included; Diabetes (including insulin initiation), Chronic Obstructive Pulmonary Disease (COPD), Anticoagulation, Warfarin Initiation and women's health.
- There were longer appointments available for patients with a learning disability or complex needs.
- The practice recognised the benefits of being proactive in supporting the health and well-being of its older population. It offered innovative, proactive and personalised care and had introduced the role of Community Practitioner, who was an experienced nurse with responsibility for the delivery of basic and extended nursing, examination and consultation skills to the whole practice population but with specific emphasis on the over 75 and housebound patients. They also acted as lead for the practice's over 75 strategy and unplanned admissions enhanced service providing patient assessment and screening. This role also provided continuity and effective communication with other organisations and a well-coordinated multi-agency approach to improving the physical and emotional health and well-being of its patients. This had resulted in a seamless service for patients with complex needs and reduced the number of referrals to community care services and admissions to hospital.
- The introduction of the role of community practitioner also demonstrated that the practice had responded to the specific needs of its community by offering extra support to patients and in particular improved access in the care of vulnerable people. For this work the practice had been nominated for an award at the National General Practice Awards under the Innovators of the Year category in both 2015 and 2016.
- Staff were committed to working collaboratively and people who had complex needs were supported to receive coordinated care. There were innovative and efficient ways to deliver joined-up care to people who used the services. The community practitioner was involved in the monitoring of older patients with a PRISMA (programme of research to integrate services for the maintenance of autonomy) score of 5, 6 & 7. The practice had extended this role to include those with a score of 3 and 4 and therefore deemed to be at low to moderate risk. This enhanced service enabled early intervention and support to be provided to a wider patient population.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice offered a wide variety of services. This included; Cardiology –Electrocardiogram (ECG), ambulatory ECG and ambulatory Blood Pressure (BP); Paediatric Ear Nose and Throat outpatient clinic; Minor

Good

Are services responsive to people's needs?

(for example, to feedback?)

Surgery; Micro suction Clinic and Audiology; Ultrasonography - a diagnostic imaging technique based on the application of ultrasound and used to see internal body structures; Musculoskeletal clinic - relating to the muscles and skeleton and including bones, joints, tendons, and muscles; Community Tele-Dermatology service.

- Musculoskeletal assessments were available on various days of the week. The practice provided referrals for NHS physiotherapy and/or for a private specialist spinal physiotherapist where appropriate, which they told us reduced the need for onward referrals to secondary care.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a lift, a fixed and a portable hearing loop and translation services available.
- Any notification that a patient had self-harmed/ overdosed was referred to the duty doctor as a priority. Following assessment, the patient would, where possible, be contacted and the patients named GP would be tasked to follow the incident up.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8am to 6.30pm daily. All requests for appointments and home visits were triaged by a GP and all patients requesting an appointment were contacted on the telephone that day by a GP to prioritise the request appropriately. This system had resulted in appropriate concerns being dealt with over the telephone, reduced time between appointment requests and access to a doctor and a reduction in patients not attending appointments. Those patients needing to be seen in person were provided with an appointment on that day or the following day. If a longer term appointment was requested by the patient and it was not considered to the detriment of that's patient's health, the GP triaging the request could book a non-urgent appointment up to eight weeks in advance.

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

- 79% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 95% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice had purchased mobile telephones for all of the GPs to be used to make out-going calls. This had resulted in a huge reduction in the pressure on the practices telephone lines and access for patients to make appointments had increased considerably.

- Patients said they were able to make an appointment with a named GP and there was continuity of care, with all requests for appointment being triaged by a GP on the day of request, prioritised and further managed by way of telephone consultation, same day or the next earliest appointment.
- The practice was proactive in its response to improving performance. In 2014, it reviewed how services were delivered. Taking the national patient and practice own patient surveys into consideration the practice trialled and subsequently adopted a full triage service. The practice told us that all patients seeking an urgent or prompt appointment were assessed by a GP. This approach, coupled with the introduction of mobile telephones for the GPs had resulted in improved patient survey performance.
- The practice offered full flexibility in its appointment system. All types of appointment, including specialist clinics such as asthma and diabetes, were available throughout the day to meet the needs of the patient, rather than the practice.
- The practice operated a text reminder system for appointments which also enabled patients to cancel or re-arrange where needed.
- The practice offered protected drop-in appointments after school/work targeted at young people to allow greater and more flexible access to the service. This has been of particular benefit when patients have wanted to discuss sensitive issues such as emotional/sexual health.
- There was a proactive approach to understanding the needs of different groups of people

and to deliver care in a way that met those needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.

- The practice had good facilities and was well equipped to treat patients and meet their needs. It offered a minor injuries service which provided care closer to patients'

homes and reduced the burden on hospital services. The minor injuries service was open to all patients including those registered with a practice elsewhere. Data for 2011 to 2014 showed that the practice rate for emergency hospital admissions was the third lowest in the CCG area, hospital admissions due to injury was the second lowest in the CCG area and the practice rate for emergency admissions of patients with long-term conditions was the second lowest in the CCG area. Patients were cared for at or near to home, by clinicians that were known to them. This was considered by the practice to be beneficial to the emotional well-being of that patient and reduced the demand for hospital services.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had a protocol to identify any request where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, Community Practitioner home visits or a clinic appointment. Such calls would be messaged through to the duty doctor, advice given to the caller and/or alternative emergency care arrangements made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. All requests were triaged by a GP.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. However, some records did not always fully evidence how and when action was taken.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a complaints leaflet displayed in a prominent position in the reception area and full guidance on the practice website.

We looked at eight complaints received in the last 12 months and found that they were satisfactorily handled, dealt with in a timely way, and with openness and transparency. Lessons were learnt from individual concerns and complaints. For example, a complaint regarding inappropriate consent was managed and responded to on the day of receipt and learning discussed at the following clinical meeting and re-visited at the subsequent meeting to ensure that the learning had been embedded into practice processes.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement of 'Delivering excellent care closer to home', which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. Staff were fully aware of key policies and lead roles within the practice.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. The practice considered audit to be a strategic tool and held an annual audit plan and an audit tracker to support that strategy. The practice built additional spare slots in to the audit plan so that they could respond in a flexible manner. For example: two slots in 2015/16 were used to audit consent and the use of "named GPs" following a complaint and a significant event respectively.
- The practice conducted further strategic monitoring and worked closely with Kent Public Health Observatory to obtain the date to manage, inform and drive performance. For example: The practice looked at the frequency of patient contact with other emergency health providers. The data was compared with other local practices. The results demonstrated that patients were up to four times less likely to seek emergency treatment from other health care providers.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

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

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

- Staff told us the practice held regular team meetings. This included clinical meetings, which GPs and practice nurses attended, reception team meetings, nurse meetings and significant event meetings. Part-time staff were paid to attend meetings to support good attendance and ensure continuity in learning. Clinical meetings included discussion/consultation in relation to complex cases. Staff were given the opportunity to provide feedback and drive change at meetings. For example: longer appointments for child immunisation following a change in the immunisation schedule, and the introduction of a new system of managing urine samples to support better accountability.
- Minutes were taken, however they were not always structured so as to be fully auditable and provide accountability.

Are services well-led?

Outstanding ☆

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted whole team meetings held every six months.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice was proactive in its response to improving performance. In 2014, it reviewed how services were delivered. Taking the national patient and practice own patient surveys into consideration the practice trialled and subsequently adopted a full triage service. The practice told us that all patients seeking an urgent or prompt appointment were assessed by a GP. This approach, coupled with the introduction of mobile telephones for the GPs had resulted in improved patient survey performance.
- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, a change to the appointment system to reduce wasted appointment time through non-attendance.
- Members of the PPG had developed a charitable arm of the group and fund raising capability. This group had purchased items for use in the practice. This included a pulse oximeter and the co-funding of automatic doors at the entrance to the practice.
- The PPG had also conducted leaflet drops in the local area to raise awareness of the practice and its services being a key part of the community.
- A member of the PPG acted as a link between the practice and local schools.
- The practice conducted a number of patient surveys including those patients who had attended for minor injuries or minor operations and also those patients who had undergone vasectomy.
- The practice gathered feedback from staff through whole staff meetings, other clinical meetings, appraisals and general discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- The practice produced a monthly staff newsletter which all members of the team were encouraged to contribute to. Topics included current affairs, staff updates, changes to protocols/policies, and reminders with regard to essential leadership roles i.e. safeguarding lead. The newsletter also enabled information to be disseminated between meetings.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. This included: Minor injuries – to relieve pressure on A&E ;(now a locally enhanced service commissioned by the CCG), Dermatology Triage; (now a local enhanced service commissioned by the CCG), Muscular Skeletal Triage; (to relieve pressure on orthopaedic outpatient waiting times, which is now a local enhanced service).

The practice was proactive in identifying and meeting a change in demand. The practice was situated in a designated government growth area with approved plans to house an additional 20,000 people. The practice consulted with NHS England, the CCG, local councils, the Patient Participation Group and the developers. To meet the anticipated future demand, the practice submitted a bid to the Estates and Technology Transformation Fund to fund new or additional premises and to resource increased capacity bringing care for patients closer to home. The bid was successful.

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

Are services well-led?

Outstanding ☆

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

The practice has worked with the Kent Public Health Observatory (KPHO) to identify models of care used by the practice that could be replicated elsewhere. Initial findings indicated that larger practices and overflow hubs were not always the answer in every environment. The results were presented locally at the Health and Wellbeing board, to the CCG, nationally at the Policy Exchange and internationally at the International GP Conference.

The care model at the practice had been recognised both locally and internationally and the practice had been nominated twice at the National General Practice Awards. We saw evidence of partnership and key involvement with the clinical commissioning group and enthusiasm at all levels within the team, to deliver the best possible outcome for the patient and achieve the best use of resources.

The practice was very supportive in its approach to staff development. Staff members were actively encouraged to seek further training and development. This included administrative staff that had been supported and developed into the roles of practice and deputy practice manager.

The practice had an innovative approach to the development of staff and encouragement of young people into a career within health care. The practice offer opportunities for work experience placements, student nurse secondments and had also offered employment under an apprenticeship scheme.