

St Lawrence Surgery

Quality Report

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

Ratings

Overall rating for this service

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Lawrence surgery on 02 August 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example they regularly shared the learning from significant events with other local practices.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met

patients' needs. For example they supported their local GP provider company to submit a bid for funding from the Prime Ministers challenge fund to provide this service across Worthing and Adur.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG). For example they installed a new telephone system in response to patient feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been developed with the patient participation group and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice including:

Summary of findings

- The practice employed a practice care co-ordinator who had a pivotal role as a liaison between the practice, patients and external agencies. This meant that members of the multi-disciplinary team (MDT), safeguarding teams, palliative care teams, pro-active care teams and carers all had a single contact point within the practice which ensured that patients had seamless care.
- The practice worked very closely with the patient participation group (PPG) and considered them an integral part of the practice team. For example the practice ran walking, singing and weight

management groups in conjunction with the PPG in order to promote patient well-being. They formed a self-care forum that led their self-help initiative producing a variety of self-care leaflets and devoting an area in the waiting room to self-care advice. The PPG chair was involved in the recruitment and selection of new GPs and sat on the interview panel. The PPG also helped organise an annual health promotion day for patients and regular evening educational events.

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 services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- 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 used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation. The practice shared learning through significant events with other practices.
- Information about safety was highly valued and was used to promote learning and improvement.
- There were comprehensive systems to keep people safe and safeguarded from abuse which took account of current best practice. The whole team were engaged in reviewing and improving safety and safeguarding systems.
- Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.
- Data showed that the practice was performing highly when compared to practices nationally. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was 94% (national average 88%). The practice contracted an independent data analyst every six months to review their Quality and Outcomes Framework (QOF) registers, risk registers and prevalence searches to ensure that they were maximising the usefulness and quality of their data.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good



Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example they had employed a care co-ordinator who acted as a liaison between the practice, patients and external agencies ensuring that patients, members of the multi-disciplinary team (MDT) teams, palliative care teams and pro-active care teams all had a single contact point which helped ensure that patients had seamless care.

Are services caring?

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.
- Patients who had difficulties with communication had their preferred form of communication flagged on their notes.
- Information for patients about the services available was easy to understand and accessible.
- There was a care co-ordinator who amongst other roles liaised with carers
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. They were involved in the formation of the local 'MIAMI' (Minor Injury Assessment & Minor Illnesses) clinics throughout Worthing and Adur.
- They used innovative approaches to providing integrated patient-centred care. For example they worked with parent carers to help children with additional needs and developed a 'medical passport' which contained important clinical and social information about them including such things as likes and dislikes. This provided other providers of health and social care with key information about their needs.

Outstanding



Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example they put a new updated telephone system in response to patient satisfaction surveys on telephone access.
- Patients could access appointments and services in a way and at a time that suited them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff, and other practices via the practice managers' forum.

Are services well-led?

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

- The practice had a clear vision to give their patients the care that they themselves would like to receive. The strategy to deliver this vision was developed with the patient participation group (PPG) and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles. Staff took great pride in their roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients using new technology and it had a very engaged PPG which influenced practice development. The PPG were integral to the running of the practice. The chair was involved in the interviewing of prospective GPs and the practice newsletter was jointly signed by the chair and practice manager. The PPG was also involved in the promotion and planning of the practice self-care initiative.

Outstanding



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

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

- The practice looked after patients in a number of residential and nursing care homes with two nominated GPs who attended ward rounds on alternate weeks.
- The practice nurse manager communicated with the residential and nursing care home staff nurses with regards to dressings and creams and the practice held regular meetings with staff of the largest nursing home that they served.
- The practice clinical pharmacist undertook medicines reviews with elderly patients and answered nursing home queries.
- Home visits were offered to the housebound patients by GPs and paramedic practitioners. Practice nurses would visit to carry out reviews of patients with diabetes and/or lung problems.
- Flu vaccines were offered to the over 60s and those considered at risk. Clinics were held on weekdays and Saturdays. They also offered a housebound flu vaccine service.
- Wheelchairs were available in the practice for patients with mobility problems.
- There was a carers register as well as register of patients who were cared for. Flexible appointments were provided for patients who were or had a carer.
- The practice held minuted monthly multi-disciplinary team (MDT) meetings to discuss the needs of patients on the palliative care register. The meeting was attended by the palliative care nurses and community nurses.
- The practice worked alongside the local proactive care team which consisted of a proactive care co-ordinator, mental health professionals, community nurses, an occupational therapist, a physiotherapist, social workers, a clinical pharmacist and the prevention and assessment team. GPs and nurses met weekly with the team to discuss patients with complex health and social care needs to ensure they had a plan of care in place that prevented unnecessary admission to hospital.
- The practice had a register of patients who were housebound. At Christmas (2015) they sent Christmas cards with the latest patient participation group (PPG) newsletter and invited housebound patients to weekly social activities and support group. The group was run in partnership with the PPG and a local nursing home provider who provided transport.

Outstanding



Summary of findings

- The practice ran walking, singing and weight management groups in conjunction with the PPG to promote the physical and wellbeing of patients.
- There was an in house podiatry service which meant older patients could receive a local service.

People with long term conditions

The practice is rated as outstanding for the care of people with long term conditions.

- The practice produced personal care plans for patients with diabetes, asthma, chronic obstructive pulmonary disease (COPD) and dementia.
- The practice held dedicated weekly diabetes clinics and a hospital diabetes specialist nurse joined a practice nurse for the clinic once a month. The diabetes lead GP and other practice staff were working with the National Association of Primary Care on a pilot scheme to assess how patients could be empowered and motivated to self manage their condition.
- The practice also held respiratory clinics. The lead GP, who also worked at the local hospital respiratory clinic once a week, saw complex cases to try to avoid hospital referral. The clinic was held in conjunction with the practice nurse. The practice's respiratory referral rate was the lowest in the CCG as a result.
- The practice also held clinics for patients with more than one long term illness, so that all of the reviews could be dealt with in one stop to save return visits.
- They produced admission avoidance care plans agreed with the patient, family and/or carer. Patients with an admission avoidance care plan were contacted and if necessary visited within 48 hours of a hospital discharge.
- Patients were encouraged and reminded to attend for reviews as well as flu, pneumococcal and shingles vaccines. This was done opportunistically, by email, personalised letters and as well as via the website, newsletters and posters.
- The practice held patient educational events throughout the year. Examples included monthly group patient education sessions for newly diagnosed diabetics and an autumn 'Keep Warm in Winter' event. There were eight such events booked for 2016.

Outstanding



Families, children and young people

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

Outstanding



Summary of findings

- The practice had both clinical and administrative child safeguarding leads. 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 child safeguarding register was updated monthly and the practice held monthly meetings with health visitors to discuss children and families at risk. They communicated regularly with school nurses and health visitors.
- The practice ran weekly baby immunisations clinics and provided six week postnatal checks. They also provided parents with 'when should I worry' educational leaflets.
- There were baby changing facilities and the practice provided a separate waiting area or room for mothers to breast feed.
- Family planning clinics were run weekly and chlamydia testing was offered to patients.
- Flu vaccines were offered for children, young people in the 'at risk' category and pregnant women.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The PPG held annual events for the children to encourage them to feel comfortable about attending the doctors' surgery such as Easter egg hunts, health promotion days and Father Christmas.
- The practice had a special interest in children with additional needs. They held a register of such children and hosted a bi-monthly Parent Carer support group. Emails containing useful information were sent to patients and their carers via a distinctive mail group and there was a social media page run by and for patients and carers in the group.
- Each child with additional needs was issued with a 'Medical Passport' which had been devised in partnership with parent carers and which contained important clinical and social information about the children including their likes and dislikes. Newly diagnosed patients and their carers were issued with an 'after diagnosis' information pack and the parents ran a website specifically for this group of parents and children.
- The practice had won an award for their work with and for children with additional needs.
- Immunisation rates were average for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Summary of findings

- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 82% (CCG 83%, national average 82%).

Working age people (including those recently retired and students)

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 offered early morning, evening and Saturday morning appointments for working people and commuters this included nurse and health care assistant appointments.
- Health checks were available on a Saturday morning in addition to the GP appointments.
- The practice held evening health education sessions.
- The practice ran a GP, nurse and paramedic practitioner triage service with flexible telephone triage, telephone consultations and follow ups.
- Patients could access GP appointments (book or cancel), request medication and view their medical records online.
- The practice had produced a large variety of “self-care” leaflets available in the surgery and on their website.
- 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. Patients could email the practice directly.
- The practice used a text messaging system that worked with their practice software to send appointment and review reminders, cancellations and general messages to their patients.

Outstanding



People whose circumstances may make them vulnerable

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

- The practice kept registers of patients living in vulnerable circumstances including homeless people, housebound patients, vulnerable adults, carers and cared for patients, those with mental health concerns and those with a learning disability.

Outstanding



Summary of findings

- The practice encouraged and reminded patients with a learning disability to attend their annual reviews. GPs visited patients at home where appropriate.
- The practice had a clinical adult safeguarding lead as well as an administrative adult safeguarding lead. 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.
- There was a carers lead who was in contact with the local carers support services for updates, training and patient events.
- Flexible appointments and urgent prescriptions were available for carers.
- The practice offered longer appointments for patients with a learning disability and those that required an interpreter.
- 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.
- The practice had regular meetings with the staff of local nursing homes.
- They worked with the proactive care team to support patients who were being cared for at home.

People experiencing poor mental health (including people with dementia)

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

- 87% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was better than the clinical commissioning group (CCG) average (82%) and the national average (84%).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 94% (CCG average 92%, national average 90%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia. Patients' care was personalised and the practice understood the needs of individual patients. For example staff

Outstanding



Summary of findings

knew to collect some patients from their cars at the time of their appointments. The practice was also flexible with appointment times and lengths for patients experiencing poor mental health.

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Several counselling services and the mental health link worker provided services on site.
- The practice had a system in place to follow up patients who had attended accident and emergency when they may have been experiencing poor mental health.
- The practice had a lead GP with a special interest in mental health and dementia. All staff had a good understanding of how to support patients with mental health needs and dementia. Many staff had had 'dementia friendly' training and the practice had been identified as a dementia friendly practice. Additionally all staff members had attended training on the Mental Capacity Act 2005.
- There were registers of patients with mental health concerns and dementia.
- The practice worked closely with the mental health trust consultants who were available for email advice and education.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 07 July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and twenty one survey forms were distributed and 129 were returned. This represented 0.86% of the practice's patient list.

- 83% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 72% and the national average of 73%.
- 88% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%.
- 89% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and the national average of 85%.
- 83% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 79% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards which were all positive about the standard of care received although two were critical of the appointments system. Four people mentioned how much they enjoyed the singing group. Patients considered the practice to be good, very good and excellent. Patients felt that staff treated them with dignity and respect and were caring, friendly and helpful.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The Friends and Family test results on the NHS choices web site showed that 67% of (36) patients would recommend the surgery to their friends and family. However 25 out of 25 patients gave the practice a five star (out of five) review on the same site and the most recent independent practice survey showed that 189 out of 201 patients were either very likely or likely to recommend the practice.

St Lawrence Surgery

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, an assistant CQC inspector and a practice manager specialist adviser.

Background to St Lawrence Surgery

St Lawrence Surgery is a medical practice offering general medical services to the population of West Worthing. There were approximately 14,271 registered patients on 31 March 2016, but due to the closure of a local practice in April 2016, this has now increased to approximately 15040.

St Lawrence Surgery is run by eight partners (five female, three male), one of whom is currently on a sabbatical and one whom is on maternity leave. The partners were supported by three salaried GPs (all female) one of whom is covering the partner who is on sabbatical. The GPs hours add up to 8.8 whole time equivalent GPs. The practice also employs eight practice nurses, two of whom are nurse prescribers, two paramedic practitioners, five health care assistants/phlebotomists, a practice business manager and deputy practice manager and a team of administrative and reception staff. The practice were taking on three new GPs over the next few months.

The practice is a training and teaching practice for GP trainees (doctors training to be GPs) and two of the partners are GP trainers. The practice also trains medical students, nurses and paramedic practitioners.

The practice runs a number of services for its patients including asthma and chronic obstructive pulmonary disease (COPD) clinics, diabetes clinics, new patient checks, ear syringing, cervical screening, family planning and sexual health clinics including coils and implants, dressings, smoking cessation advice and treatment and holiday vaccines and advice. The practice also offers NHS health checks.

The practice also carry out minor surgery and cryotherapy procedures.

Services are provided from:

St Lawrence Surgery,
79 St Lawrence Avenue,
Worthing, West Sussex,
BN14 7JL

The practice is open between 7.30am and 7pm on Monday and 7.30am to 6.30pm on Tuesday to Friday. Phone lines open at 8am each day. Appointments are available from 8.30am to 11.30am every morning and 3pm to 6.30pm in the afternoon. Extended hours appointments are offered from 7.40 am each day and until 7pm on a Monday as well as Saturdays from 9am to 12pm for pre-bookable appointments only. Extended hours surgeries are available with GPs and nurses and are pre-bookable. In addition to pre-bookable appointments that can be booked up to three weeks in advance, urgent appointments are also available for people that need them.

Appointments can be booked online, via telephone or by visiting the surgery.

At all other times patients are asked to call 111 to be directed to the appropriate out of hours care and advice.

The practice population has a slightly higher number of patients over 65 years of age (20%) than the national

Detailed findings

average of 17% but this is lower than the clinical commissioning group (CCG) average of 25%. It also has a slightly higher number of patients under 18 years (22%) than the national average (21%) and CCG (18%). There is a slightly higher than average number of patients with a long standing health condition (56%), (national average 54%). The percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the national and local averages, except for deprivation in older people that is similar to the local average. The practice has a higher than national average number of patients in nursing homes (1.1% compared with a national average of 0.5%).

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 02 August 2016. During our visit we:

- Spoke with a range of staff GPs, nurses, paramedic practitioners, health care assistants, management and administrative/reception staff as well as 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.

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 or one of two clinical governance leads, in confidence, of any incidents and there was a recording form available on the practice's computer system. All clinical complaints were considered as significant events. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed, 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 and they were discussed as part of monthly significant events meetings and also at clinical meetings. Important significant events were shared with other practices via the practice managers' forum.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw that the practice care co-ordinator put the information together and added them to the meeting agendas. Learning was based on a thorough analysis and investigation of things that went wrong. All staff were encouraged to participate in learning and to improve safety as much as possible. Opportunities to learn from external safety events were identified. Learning points were distributed to all staff where appropriate. Issues were often revisited two or three times to ensure actions had been implemented. In the last year nine incidents were reported. We saw evidence that lessons were shared and action was taken to improve safety in the practice. The practice shared learning with other practices. For example, the practice had discussed an incident that had occurred elsewhere and was discussed at a practice manager's forum meeting. A patient had read another's notes on a desk and that

patient's confidentiality had been breached. The incident was reviewed three times at significant events meetings with the outcome being a policy that desks should be kept clear of all papers.

Overview of safety systems and processes

There were comprehensive systems to keep people safe and safeguarded from abuse which took account of current best practice. The whole team was engaged in reviewing and improving safety and safeguarding systems.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Comprehensive policies were accessible to all staff on the computer shared drive and laminated prompts were in all consulting rooms. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding children and one for adults and they deputised for one another. There was also a safeguarding administrative lead. If patients considered to be vulnerable failed to attend an appointment the safeguarding lead would follow up with phone calls to discover why and arrange further appointments. The practice retained a child safeguarding register, a register for children considered to be at risk, an adoption register and an under-fives register. Safeguarding meetings were held monthly and attended by the practice care coordinator, all the GPs, school nurses and the health visitor. We saw that a recent child safeguarding meeting had been attended by 15 practice staff members. GPs attended external safeguarding meetings 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. We saw written evidence that their safeguarding system had been highly commended as a system to be shared with other practices at a clinical commissioning group safeguarding meeting and that one practice had already adopted aspects of their system.
- The practice had an online service protocol and would raise a safeguarding alert and possibly deny a parents or

Are services safe?

carer's application for proxy access to a child or vulnerable adults' online account if it was likely to be abused. We saw examples where such requests were discussed.

- A notice in the waiting room and consultation rooms 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). All staff that chaperoned a patient entered the fact in the notes. In the previous year the practice had offered patients the service 930 times of which 207 were accepted and 723 declined.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The lead practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. All new staff received one to one training at induction with the infection control lead. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. We noted on the day that one of the outside medical waste storage bins was open. The bin contained sealed sharps bins that could not easily be opened. The infection control lead told us that she had checked that the bin was locked that morning. We saw the practice had very recently had a waste disposal assessment carried out and no issues had been found. The caretaker checked the bins every evening and was certain it was locked the night before. The practice had immediately moved the bin contents back in to the practice and ordered a new bin without prompting. They had obtained a quote for fencing to surround the bin area, prior to the inspection and we saw photographic evidence that within three days the bins were surrounded by a locked fence.
- 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 and audited 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 CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The GPs also carried out medicine reviews (we saw 10 recent reviews). Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. 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. The practice had employed a clinical pharmacist who carried out new medication reviews.

- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, interview notes and scoring, 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 effective procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. 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 maintained a comprehensive maintenance and service checklist containing contact details of frequency of servicing and last and next dates of service. 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).

Are services safe?

- Arrangements were in place 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. All staff were multi-skilled and covered one another. The GPs used a local GP network to access locum cover and used the same locums where possible. New locums received a comprehensive locum pack prior to starting.
- We saw that staff with a physical disability, were of child bearing age or under stress had a full work place risk assessment carried out and that actions were implemented as a result.

Arrangements to deal with emergencies and major incidents

There were comprehensive arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers and panic buttons in all the consultation and treatment rooms which alerted staff to any emergency. A panic button in reception was linked to the police station. The practice had an emergency policy which detailed when to use the panic alarm and when to involve the police.
- All staff received annual basic life support training and there were emergency medicines available. The practice employed two paramedics and at least one was on duty daily. We saw a record of an incident when two patients collapsed at the same time on the ground floor and one on the first floor. We saw that both were dealt with correctly. Analysis of the incident had led to the purchase of a privacy screen for upstairs.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had comprehensive business continuity plans in place for major incidents such as power failure or building damage. The plans, held at home by the practice manager, their deputy, the partners and caretaker, included emergency contact numbers for staff.

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. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- All medical alerts and NICE guidelines were sent to all clinicians by email and the clinical commissioning group also provided updates at quarterly training events. Searches were run by the practice manager and data and quality lead and passed to the clinical leads for action. Any concerns were discussed at monthly significant event meetings and at regular clinical meetings.
- All staff had access to guidelines and alerts on the shared drives or hard copies kept in the office 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 and had been for 10 years. The practice had employed a data and quality lead who with their administrative team and clinical lead had recently put in place a workflow management and redirection process that redirected some administrative tasks away from GPs to the administrative team and with the aim of saving a significant amount of GP time over a year. The data and quality lead had been on a week long training course and trained the team who worked to protocols. The work was being regularly audited and further changes implemented.

The practice constantly monitored QOF data and shared it with clinical team so that an understanding of performance was maintained. We saw that the practice employed an independent data analyst every six months to review their QOF registers, risk registers and prevalence searches which ensured a high standard of data quality.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was better than the clinical commissioning group (CCG) or national average. For example the percentage of patients with diabetes, on the register, in whom the last blood pressure reading was 140/80 mmHg or less was 83% (CCG average 80%, national average 78%).
- Performance for mental health related indicators were better than the clinical commissioning group (CCG) or national average. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record was 94% (CCG average 90%, national average 88%).

There was evidence of quality improvement including clinical audit.

- There had been twelve clinical audits completed in the last two years, seven of these were two cycle audits where the improvements made were implemented and monitored. The other five audits were first cycle audits where the start date for the second cycles had already been planned.
- The practice ran regular searches to monitor aspects of clinical care such as PSA levels (a blood marker used both to screen for and monitor for possible prostate cancer). Such information was added to a spreadsheet which contained information such as the date of the test, the patient's last appointment date and their next and was circulated to the relevant clinical staff.
- We saw written evidence that the CCG clinical advisor had commented on the very high standards of the practice's clinical governance systems.
- The data and quality lead ran regular searches on specific clinical issues to ensure that patients were being monitored to a high standard and that optimum patient outcomes were achieved. For example a safety audit of the repeat prescribing and medication

Are services effective?

(for example, treatment is effective)

review protocol was carried out. A random sample of repeat prescriptions were analysed. Several scripts did not meet the review criteria. Findings were discussed at a practice meeting and changes were made to procedures and protocols as a result which improved patient safety.

- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- The practice manager was involved in sharing best practice with other practices via the practice managers' forum.

The IT lead had produced disease templates and protocols within the practice software for use by the clinical staff covering every disease area and a wide variety of tests. Some of the practices templates, for example the care plan template had been shared with and used by other local practices.

Effective staffing

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

- The practice had a comprehensive induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- 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. The practice held four in house half day training sessions per year and staff also attended four external training half days They received 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 and in-house training. All staff training was monitored on a comprehensive spreadsheet that was reviewed monthly to ensure that all staff were up to date with mandatory training

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. Any important information was cascaded by the administration team to all staff that needed it providing they had consent to do so.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We saw that care plans and 'medical passports' for children with additional needs were uploaded on to a system shared by the ambulance service.

The practice had employed a care co-ordinator who among their roles acted as a liaison between the practice, patients and external agencies. This meant that members of the multi-disciplinary team (MDT) teams, palliative care teams and pro-active care teams all had a single contact point. The patient care co-ordinator was also the liaison between all the different staff groups and also with patients. The same staff member was the safeguarding administration lead.

The practice held weekly pro-active care MDT meetings to review all unplanned admissions and patients requiring follow up reviews were put on the list for the triage team to contact. The triage system ensured all patients requiring a follow up would be contacted. 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,

Are services effective?

(for example, treatment is effective)

including when they were referred, or after they were discharged from hospital. Meetings took place with the proactive care team on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice also held monthly meetings with the palliative care team as part of the Gold Standards Framework for palliative care. All patients on the palliative care register were discussed and all deaths were reviewed.

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.
- We saw evidence that 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.
- We saw an example of where consent was obtained through an interpreter.

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 children with additional needs. Patients were signposted to the relevant service.
- Diet advice was available from the nurses and smoking cessation advice was available from the health care assistants. They also held a smoking cessation drop in clinic between 4pm and 6pm on Wednesday afternoons.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 83% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured a

female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccines given were comparable to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 90% to 98% (CCG 93% to 97%) and five year olds from 87% to 97% (CCG 89% to 96%).

Staff were consistent in supporting people to healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. For example the practice did a lot of work trying to identify patients at risk of developing diabetes and educating them to try to avoid them becoming diabetic. They had identified 757 pre-diabetic patients. Each were sent an explanatory letter and signposted to help with lifestyle change.

Local and national support groups exhibited at annual health promotion days organised in conjunction with the patient participation group (PPG) and we saw letters and cards of thanks from several of the groups. They had additionally in partnership with the PPG organised eight patient education events during 2016. Titles included 'a gift of life-organ donation' and 'Signs and symptoms of dementia and how to cope'. All events were evaluated to assess outcomes and impact on patients. For instance after a meeting on managing Chronic Obstructive Pulmonary Disease (COPD), all those that filled in a questionnaire scored highly on how to manage their COPD after the meeting as compared to their scores before the meeting.

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. Practice nurses had run a health promotion day where over 40 patients had presented for a health check in the afternoon. They identified 10 patients with previously undiagnosed hypertension (raised blood pressure) of which three needed immediate referral to a GP and six patients that required a follow up for raised blood glucose levels. The practice targeted specific patients groups for additional support. For example the ran an audit

Are services effective? (for example, treatment is effective)

on all men between 40 and 60 who hadn't attended the GP in five years and invited them to the open day for health

checks. The practice in partnership with the PPG formed a self-care forum that led their self-help initiative. They produced a variety of self-care leaflets and devoted an area in the waiting room to self-care advice.

Are services caring?

Our findings

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.
- Staff had mandatory training in customer service. They also undertook training on, equality and diversity, hearing awareness, information governance and stress management.

All of the 32 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:

- 94% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.

- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% 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. When care plans were discussed with nursing home residents, they involved the patient, were witnessed by a nurse and if appropriate shared with the patient's next of kin. Individual GPs were responsible for the care plans and patients retained a copy if they wished to do so.

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 87% and the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

Are services caring?

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 format.
- The practice also offered a signing interpreter service
- They offered large print patient leaflets and information sheets where possible.
- The practice had two hearing loops and an additional portable loop.
- Patient notes identified those who were deaf, blind or doctor, nurse or needle phobic, or if they had an additional need so that the appropriate adjustments could be made to their care. There were 136 patients registered who were hard of hearing or deaf (0.9%) and 37 partially sighted or blind (0.2%)
- All patients with communication difficulties had this highlighted in their notes so that the best method of communication was used.

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 employed a care co-ordinator who amongst many other roles worked closely with the Parent Carer support group to contact carers directly to assess any additional help that they may require. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 190 patients as carers (1.3% of the practice list) and 220 patients had a carer (1.5% of the list). The practice also recorded those that had been but were no longer a carer. All carers received a carer information pack which was tailored to the problems of the cared for patient. Notice boards and screens in the waiting room contained information to direct carers to the various avenues of support available to them. The practice had a 'support for carers' educational meeting planned for September 2016.

Staff told us that if families had suffered bereavement, their usual GP contacted them and sent them a sympathy card and bereavement pack. This call was either followed by a patient consultation and/or by giving them advice on how to find a support service if appropriate.



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 group (CCG) to secure improvements to services where these were identified. For example the practice worked with other local practices on the formation of the local Minor Injury Assessment & Minor Illnesses (MIAMI) clinics throughout Worthing. These clinics allowed surgeries to book patients one off appointments with a clinician when their urgent appointments were full. They also ran weekend clinics and a children's walk in service. Their use was closely monitored.

- The practice offered a 'Commuter's Clinic' in the mornings from 7.40am and until 7pm on Mondays and from 9am to 12pm on Saturdays for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Regular ward rounds were held at residential and nursing homes.
- Same day appointments were available for children and those patients with medical problems that required an urgent consultation.
- They used innovative approaches to providing integrated patient-centred care. The practice had a special interest in children with additional needs. They held a register of such children and hosted a bi-monthly Parent Carer support group. Emails containing useful information were sent to patients and their carers via a distinctive mail group and there was a social media page for patients and carers in the group. Each child with additional needs was issued with a 'Medical Passport' which had been devised in conjunction with the children and their families and which contained important clinical and social information about them including such things as likes and dislikes. Newly diagnosed patients and their carers were issued with an 'after diagnosis' information pack. At the time of the inspection 35 children and their families held a medical passport. The practice had won a national NHS sponsored award for their work with and for children with additional needs. We saw testimonies from parent carers describing how much the practice's approach had improved theirs and their child's lives.
- The practice in partnership with the patient participation group (PPG) formed a self-care forum that led their self-help initiative. They produced a variety of self-care leaflets and devoted an area in the waiting room to self-care advice. The practice promoted self-care and shared their experiences through presentations to professional and public groups and in engagement with the media. In a recent patient survey 64% of patients had seen the self-care fact sheets either in the waiting room or on the website and 64% of those said they had helped them manage their condition better. The advice leaflets were devised by the self-help forum consisting of patient participation group (PPG) members, the practice care co-ordinator and a CCG representative. All advice sheets were reviewed by clinicians before publication.
- The practice had a housebound register. At Christmas (2015) they sent Christmas cards with the latest PPG newsletter and invited housebound patients to a weekly social activities and support group. The group was run in partnership with the PPG and a local nursing home provider who provided transport.
- The practice ran walking, singing and weight management groups in conjunction with the PPG to help improve the physical and mental well-being of its patients. An evaluation of an eight week weight management course showed that out of 13 patients who completed the course, 85% lost weight and 31% lost at least 5% of their initial body weight. Also 77% were eating more healthy food and were doing more exercise. We also saw several examples of feedback from the singing group describing how much it had done to improve their confidence generally.
- Housebound patients were invited to the health promotion day and transport was offered.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities, two hearing loops and an additional portable loop available. The disabled facilities had a light that flashed to alert a patient with hearing loss in an emergency.



Are services responsive to people's needs?

(for example, to feedback?)

- There were braille signs and pictures to aid patients with learning difficulties on toilet doors. The practice had automatic doors, wheelchair ramps and wheelchairs were available for patients with mobility problems. There was a low desk for wheelchair users at reception. A lift improved first floor access.
- The practice provided a separate waiting area or room for mothers to breast feed and provided baby changing facilities.
- Children with additional needs and patients with learning disabilities could wait wherever they were most at ease (for example in their cars) and staff would go out and call them when it was their turn.

Access to the service

The practice was open between 7.30am and 7pm on Monday and 7.30am to 6.30pm on Tuesday to Friday. Phone lines open at 8am each day. Appointments were available from 8.30am to 11.30am every morning and 3pm to 6.30pm in the afternoon. Extended hours appointments were offered from 7.40 am each day and until 7pm on a Monday as well as Saturdays from 9am to 12pm for pre-bookable appointments only. Extended hours surgeries were available for GPs and nurses and were pre-bookable. In addition to pre-bookable appointments that could be booked up to three weeks in advance, urgent appointments were also available for people that needed them.

Appointments could be booked online, via telephone or by visiting the surgery.

At all other times patients were asked to call 111 to be directed to the appropriate out of hours care and advice.

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

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and the national average of 76%.
- 83% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.

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

There was an effective system in place for assessing patients who wanted urgent appointments on the day. The receptionists took the call and directed them according to a clear written call handling protocol. The messages were passed to the triage team for the day which consisted of a GP, nurse and paramedic practitioner to call the patients back. Patients were given telephone advice or a face to face appointment as appropriate. The triage team also contacted any patients requiring follow up for instance those who had recently been discharged from hospital.

The practice had recently installed a new telephone system in response to patient feedback on telephone access.

The practice used the same system to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

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.
- 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. This was available in the waiting room as posters and leaflets and on their website.

We looked at 15 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. We saw that all clinical complaints were also considered as significant events. The GP complaints lead and practice business manager held an



Are services responsive to people's needs? (for example, to feedback?)

annual review of complaints and disseminated learning points from the review to all staff. For example following a complaint about the repeat prescription process we saw that the practice made changes to the process.

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 mission statement and values based on giving their patients the care that they themselves would like to receive. Additionally they wished to provide good accessible medical care to their local community, a healthy work environment where all members of their team were valued and to keep abreast of changes in the NHS. The strategy to deliver this vision had been produced with stakeholders including the patient participation group (PPG) and was regularly reviewed and discussed with staff.

- The practice had a mission statement which was also available on the website and staff knew and understood the values. It appeared on the front sheet of staff appraisals.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. They produced an annual practice development plan which included a five year strategic overview.
- The practice produced an annual report which was available on the website which included the practice philosophy.
- Succession planning was included in the strategy and we saw current examples where a key member of staff was training their deputy to take over when they retired.

Governance arrangements

The leadership governance and culture of the practice were used to drive and improve the delivery of high-quality person-centred care. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.

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 available to all staff. A comprehensive list of policies and

protocols was maintained with review dates and responsible staff members. This was circulated monthly with the reviews for the coming month highlighted for action.

- A comprehensive understanding of the performance of the practice was maintained through regular audit, regularly reviewing performance data, significant events and patient feedback. The practice had employed a data and quality lead and had commissioned six monthly external audits of their data.
- 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, and we saw evidence that 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.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed and we saw that high standards were promoted and owned by all practice staff and teams worked together across all roles. When we interviewed staff it was clear that they took great pride in their roles and were keen to describe how they made a difference to patient care.

Are services well-led?

Outstanding



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

- We saw that there was an extensive system of regular meetings which were booked ahead for the whole year. These included meetings involving all the staff about four times a year and practice planning meetings twice a year. There were regular partner meetings, monthly palliative care meetings and also child safeguarding, significant event and admission avoidance meetings monthly. There were also monthly clinical meetings, nurse and health care assistant meetings, practice nurse supervision meetings and reception meetings. The team were sent weekly email updates of any changes or issues within the practice by the practice manager. There were also regular meetings with staff of the large nursing home that the practice served. All meetings were minuted.
- 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. This had been confirmed in a recent staff survey on practice culture. We noted team away days were held, the most recent being a team building and social event in May 2016.
- 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. We saw an example where all staff had attended an 'altogether' meeting at which they raised concerns about a lack of appointments over the summer. As a result the partners held a partner meeting and made significant changes to their working patterns to improve patient access including the cancellation of their leave and working on days off. This was communicated to the staff via email and an urgent reception team meeting. The partners showed a clear regard for both staff and patient welfare.
- The practice was a 'mindful employer'. We saw that staff were helped with any difficulties and positive action was taken to ensure their health and welfare.
- We saw evidence that any staff member with a physical disability, or who was of child bearing age or under stress had a full risk work place assessment carried out and that action was taken as a result.
- Staff were offered free counselling if required.

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. Feedback was gathered from patients, through the patient participation group (PPG) and through surveys, the website, suggestion box and complaints received. They had a very engaged PPG which influenced practice development. The PPG met regularly, carried out patient surveys, submitted proposals for improvements to the practice management team and helped run many practice events. The chair was involved in interviewing prospective GPs and the practice newsletter was jointly signed by the chair and practice manager. The PPG were involved in the promotion and planning of the practice self-care initiative. A newsletter jointly signed by the practice manager and PPG chair was sent to patients every two to three months. Approximately 2500 patients were on the practice emailing list. The practice had met with the PPG to discuss the recent patient survey and discussed and published an action plan in response.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had gathered feedback from staff through an annual staff survey, staff away days, staff meetings, appraisals and discussion. Staff were included in six monthly practice planning meetings where they were encouraged to advance ideas and become involved in shaping the direction that the practice was moving. The practice had recently carried out a staff survey which showed high levels of staff satisfaction. It showed that staff strongly agreed that there was no blame culture, that the organisation was open to criticism and that the practice treated people fairly. The survey also identified that the GP Partners and Practice Management felt that communication between partners and staff was better than the staff did. Staff were asked for suggestions to help resolve the mismatch and were considering this. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They felt involved and engaged to improve how the practice was run.

Continuous improvement

Are services well-led?

Outstanding



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

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. One GP represented the local practices in a project to make primary care more sustainable in the future. The practice had undertaken a large piece of work to improve the workflow. This meant that correspondence which needed the GPs attention was highlighted to the right GP as soon as possible, whilst ensuring items that could be dealt with without a GPs attention were picked up by an appropriate staff member. This reduced the volume of correspondence that GPs received allowing them to focus on priorities. The practice was a training practice for GPs and also medical

and nursing students from whom we saw examples of very positive feedback. The lead respiratory GP worked in the chest clinic at the local hospital and reviewed respiratory referrals which were the lowest of the local practices. The practice manager had had several articles published in professional journals. The diabetes lead was clinical diabetes lead for the CCG and the practice manager was chair and co-chair of two practice manager groups. The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. They were involved in the formation of the local 'MIAMI' (Minor Injury Assessment & Minor Illnesses) clinics throughout Worthing and Adur.