

# Hastings Medical Practice and Walk-In Centre

## Quality Report

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hastings Medical Practice and Walk-In Centre on 27 July 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
  - Risks to patients were assessed and well managed.
  - Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience 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.
  - 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.
  - The practice provided both general practice services with a list of patients registered to the practice and also a GP led walk in service open to unregistered as well as registered patients.
  - Patients registered with the practice said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
  - The practice was open from 8am to 8pm and saw all patients that presented during that time.
  - The practice saw 98% to 99% of patients using the walk in service within two hours.
  - 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 provider was aware of and complied with the requirements of the duty of candour.
- The areas where the provider should make improvement are:

# Summary of findings

To ensure that maximum and minimum fridge temperatures are recorded and reviewed on a daily basis.

To review systems for recording of carers to ensure that all patients who wish to identify themselves as carers have this documented.

**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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- 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 in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed with the exception that fridge temperatures were not always recorded on a daily basis.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were mainly at or above average compared to the national average.
- QOF outcomes for diabetes, the uptake for national screening programmes and the uptake for childhood immunisations were generally lower than the national average. However we saw that action had been taken to address all of these issues.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- 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 with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



### 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.

Good



# Summary of findings

- 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?

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 (CCG) to secure improvements to services where these were identified. For example the practice were engaged in a new locally commissioned service to improve the system of recording and sharing of care plans with other agencies where appropriate for vulnerable patients.
- Patients registered with the practice said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- We saw instances where the practice responded promptly to the needs of patients whom they hadn't previously encountered, putting in place both clinical care and facilitating urgent social care at short notice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



## Are services well-led?

The practice is rated as good 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.

Good



# Summary of findings

- 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 in place 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

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs where appropriate.

Good



### People with long term conditions

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Chronic disease teams consisted of a GP, a lead nurse and an administrator.
- Each recognised long term condition was managed by a team consisting of a lead GP, lead nurse and an administrator who would regularly review the registers and ensure that patients were reviewed and managed in line with current guidelines. Teams would ensure that they remained up to date with current teaching and changes in guidelines would be discussed at monthly clinical meetings.
- Longer appointments and home visits were available when needed.
- 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.
- The practice had just employed a clinical pharmacist, whose role was to assist with the medicines management of patients with complex conditions.

Good



### Families, children and young people

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

Good



# Summary of findings

- 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. Immunisation rates were relatively low for some standard childhood immunisations.
- The local safeguarding lead nurse was informed of the
- Children using the walk in centre were seen by a nurse for assessment as a priority
- We saw that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The percentage of women aged 25 or over and who had not attained the age of 65 whose notes recorded that a cervical screening test had been performed in the preceding five years was 82.2% (CCG average 83.9%, national average 82.6%).
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

## **Working age people (including those recently retired and students)**

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted 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 reflected the needs for this age group.
- The practice was open from 8am to 8pm every day of the year.
- The practice had recently introduced a text messaging appointment reminder service.

Good



## **People whose circumstances may make them vulnerable**

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

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.

Good



# Summary of findings

- Because of the location of the practice and the fact that it was also a walk in centre, the practice saw a significant number of patients with complex health and social care issues.
- The practice would take vulnerable patients, including the homeless, who accessed them through the walk in service on to their registered patient list. The practice used the surgery address to register them and tried to retain updated phone and contact records for them. We saw an instance where this occurred on the day of the inspection when extensive efforts were made to help a patient with medical and social care problems.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice were taking part in a new locally commissioned service to improve the system of recording and sharing of care plans with other agencies where appropriate for vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice had been part of a pilot scheme in to a new social prescribing service to give help and advice to vulnerable patients on a wide variety of social issues such as housing, debt, benefits, relationships, parenting and general wellbeing. The service was now available in the same building and the practice regularly referred patients to the service. A session was also held within the practice one evening a week.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documenting safeguarding concerns and how to contact relevant agencies in normal working hours and Out of Hours. We saw examples of where the practice had made appropriate safeguarding referrals.

## People experiencing poor mental health (including people with dementia)

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

- 100% 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 national average (84%). However the practice had a very low percentage of patients over 65 and this equated to three patients.

Good



# Summary of findings

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate was 93% (CCG average 93%, national average 88%).
- The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding five years was 100% (CCG average 92%, national average 89%).
- The practice additionally had a significant number of registered patients who had been diagnosed with personality disorders.
- 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.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place 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.

# 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. Of 359 survey forms that were distributed, 94 were returned which was 2.8% of the practice population.

- 77% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (79%) and national (73%) averages.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the clinical commissioning group (88%) or national (85%) average.
- 80% of patients described the overall experience of this GP practice as good compared to the clinical commissioning group (87%) or national (85%) average.

- 76% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the clinical commissioning group (79%) or national (78%) average.

Of the 10 patient Care Quality Commission comment cards we received eight were positive about the service experienced although five of the 10 respondents felt that the wait to be seen at the walk in centre was rather long. The two cards that were not positive about the experience were walk in patients that felt that the wait to be seen was too long. Patients who commented on the care that they received said they felt the practice offered an excellent service and staff were helpful, kind, caring and friendly and treated them with dignity and respect.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The results for the Friends and Family Test that were currently on the NHS Choices website showed that 95% of patients would recommend the practice to their friends and family.

## Areas for improvement

### Action the service SHOULD take to improve

The areas where the provider should make improvement are:

To ensure that maximum and minimum fridge temperatures are recorded and reviewed on a daily basis.

To review systems for recording of carers to ensure that all patients who wish to identify themselves as carers have this documented.

# Hastings Medical Practice and Walk-In Centre

## 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, a practice nurse specialist adviser and a practice manager specialist adviser.

## Background to Hastings Medical Practice and Walk-In Centre

The Hastings Medical Practice and Walk-In Centre holds an Alternative Personal Medical Services (APMS) contract with the Hastings and Rother Clinical Commissioning Group (CCG) and offers general practice services to the people of Hastings. There are approximately 3,400 registered patients. Additionally the practice offers a GP led walk-in centre and will accept all patients, whether registered at the practice or not, for one off consultations between the hours of 8am and 8pm Monday to Sunday. The population of the Hastings area which the walk in centre covers is 183,000 although this figure increases during the summer period.

The Hastings Medical Practice and Walk-In Centre is run by Integrated Care 24 (IC24) a non-profit making social enterprise organisation that provides Out of Hours services, 111 services and GP services across central and southern England.

The practice has five regular salaried GPs (three male and two female) one of whom is designated Medical Services Director. They are supported by three practice nurses one of whom was an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions, an assistant practitioner, one health care assistant, a team of receptionists and administrative staff, the Head of Primary Care, Walk In Centres and Pharmacies and the Patient Services Manager. The practice have just appointed a clinical pharmacist. The provider IC24 also provides services at a walk in centre at Eastbourne and the Medical Services Director and Head of Primary Care also manage that centre. There were plans in progress to use nursing staff with specialist skills across both sites.

All patients on the practice list have a named GP although the GPs operated a shared list system so patients could choose which GP they saw.

The practice runs a number of services for its patients including chronic obstructive pulmonary disease (COPD) and asthma clinics, child immunisations, contraception advice, diabetes clinics, new patient checks, travel health checks and vaccines, smoking cessation advice and weight advice.

Services are provided at

The Ground Floor

Hastings Station Plaza Health Centre,

Station Approach

Hastings

East Sussex

TN34 1BA

# Detailed findings

The building is owned and maintained by NHS Property Services and contains other GP surgeries as well as a variety of other health and social services.

The practice is open between 8am and 8pm Monday to Sunday and access to the walk in service is available during those hours. Booked appointments for registered patients are available from 8am to 6.30pm daily including weekends. In addition to pre-bookable appointments that can be booked up to four weeks in advance, booked urgent appointments are also available for registered patients that need them. Registered patients also have access to walk in appointments from 8am to 7.50pm Monday to Sunday.

The practice are contracted to see 18,000 patients via the walk in centre per year. In the year July 2014 to June 2015, they saw 18,811 walk in patients.

There is a very diverse mix of ethnicities amongst the patients of the practice with 34% not having English as their first language.

The practice exhibits a very high turnover of patients.

The percentage of registered patients suffering deprivation (affecting both adults and children) is significantly higher than average for England. The practice states that many of their patients are homeless with complex health and social care issues and have difficulty engaging with other practices or local providers. The practice population has a much lower number of patients 65 plus than the national average (93% are under 65 years and 70% are under 45 years) and a higher than average group of patients in the 20 to 35 age group. There is also a higher than average number of patients of nine years of age or less, with a much higher than average number of patients below four years of age. There are an average number of patients with a long standing health condition compared with the national average and an average number of patients with a caring responsibility. There have a higher than average number of patients who are unemployed.

## 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 27 July 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, health care assistants, management staff and administration/reception staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- 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)

# Detailed findings

- 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 of any incidents and there was a recording form available on the practice's computer system. 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 of the incident, received reasonable support and truthful information. Patients received a written apology at the outset and at the conclusion of the investigation and were kept informed of any progress throughout. They 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 shared results and learning at minuted clinical and administration meetings and also directly to all staff via email. Locum staff were also included in emails about significant events. Administration and reception staff were invited to meetings where significant events were discussed.
- All significant events and complaints were also reported to the central clinical governance teams at the head office of IC24 and shared at monthly central clinical governance meetings to allow learning to be shared across the organisation where appropriate.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a newly registered patient with a history of anaemia (low red blood cell count) was admitted to hospital with a different condition requiring blood thinning medicines. On discharge the patient was seen by clinicians at the practice and on investigation found that the anaemia was worsening and had been whilst in hospital, but probably not due to the blood thinning medicines. The

issues were scrutinised by the lead GP and several areas for learning identified. Particularly in relation to discharge from hospital and management at the practice. He also identified areas where management went well. An action plan was drawn up and carried out and the event was on the agenda to be discussed further at the next clinical meeting.

### 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:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff on the shared computer drive. 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 child safeguarding and one for vulnerable adults. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. The practice kept a record of children who were on the risk register and also flagged their notes. 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. Nurses, health care assistants and all administration and reception staff were trained to child protection or child safeguarding level two. Safeguarding training for all staff was updated annually. We saw examples where appropriate referrals had been made to local safeguarding teams. Local authority guidelines had been printed out and were available in all clinical rooms.
- A notice in the waiting room and on the front of all consulting room doors advised patients that chaperones were available if required. Nurses were usually used as chaperones, but all staff had been trained for the role and had received an Enhanced 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).

## Are services safe?

- 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 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. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, security and disposal). The only exception to this was that although maximum and minimum fridge temperatures were recorded and none were outside the maximum and minimum ranges, they were not always recorded on a daily basis. 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 CCG 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. We did note that although records of the printer prescription forms numbers that came in to the practice were recorded, there wasn't a separate record kept when printer prescription forms were signed out to a particular room. However this had been rectified by the time we left and the numbers of the printer prescriptions allocated to each room had been recorded. 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. We saw that PGDs were correctly signed and within date. The Health Care Assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice did not keep stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) on the premises.
- The practice had a recruitment policy which was the same one that was used across all of IC24's operations.

All staff recruitment files were held at IC24's head office in Ashford Kent so they could not be viewed on the day of inspection. However the Care Quality Commission had carried out a thorough inspection of IC24's recruitment processes during an inspection of their head office on 12 and 13 July 2016. The team had reviewed 17 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 (DBS checks). They had found two cases where the records were incomplete but no evidence of systematic failure.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were 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 corridor which identified local health and safety representatives. The practice had up to date fire risk assessments and staff had received training in fire safety. Fire alarms and emergency lighting were tested weekly and evacuation drills were carried out twice yearly. 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. A legionella risk assessment had been carried out by the landlord for the whole building, but had not furnished the practice with a copy despite requests. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However regular water temperature monitoring and water sampling and flushing were carried out regularly by the buildings management.
- 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. We saw that the rotas were regularly reviewed and that staff members had specific colleagues who covered their work and who couldn't take leave at the same time as them. The recruitment

## Are services safe?

strategy was to replace staff that left with those with similar skills. All of the practice nurses were being put through the nurse prescriber course. Unforeseen absences were covered by locums and where possible locums that were well known to the practice were used.

- Locums were sourced locally via agencies, all documentation was seen and copies retained by the practice manager. All staff were asked for feedback on locum GPs and this was analysed at the practice and fed back to head office. Locums with unsatisfactory feedback were not employed again and their agencies were informed of the reasons why.
- Locums who were employed by the practice were included in training, were invited to both informal and formal clinical meetings and emailed information on significant events, NICE guidelines MHRA alerts and other relevant updates.
- The work of all locums was audited on a regular basis by the Medical Services Director.

### **Arrangements to deal with emergencies and major incidents**

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There was also a panic button in each room. We were told of a recent example where a patient who had a cardiac arrest outside was successfully resuscitated by the practice team.
- 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. First aid kit and accident books 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 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. Copies were kept in reception as well as at several off site locations.

# 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. All alerts arrived via the practice manager's email address and were forwarded to the relevant staff. The alerts were also stored in the shared drive as well as a hard copy in reception. The practice manager and lead GP discussed the alerts and actioned them accordingly. Relevant alerts and guidelines were discussed at clinical meetings. All staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. All locums were also sent alerts and guidelines in line with practice policy.
- The practice monitored that these guidelines were followed through risk assessments, review at multi disciplinary team meetings and review during protected time at half day meetings every two months.

### 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 95% of the total number of points available. Exception reporting was generally high (21.9% over all, clinical commissioning group average 8.9%, national average 9.2%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

The practice explained that all patients who had been identified as requiring reviews under the QOF system were sent three reminder letters and also called by phone, before being recorded as exceptions. The practice made repeated attempts to explain to patients why attendance for review was important and where possible, booked interpreters even where the patient had some English, in

case there was a misunderstanding regarding the need to be seen. A decision to exception report the patient was only taken after the patient's notes had been reviewed by a lead clinician or manager. Once recorded as an exception, the practice still continued to try to contact the patient. The practice felt that the main reasons for the high exception reporting was the high level of deprivation amongst its patients and also cultural and language barriers that they attempted to overcome. The population was also quite mobile as the practice often took on as registered patients people that presented through the walk in centre without a GP. For example from 01 July 2014 to 30 June 2015 the practice took on 802 new patients and 561 left the list. Another issue was that quite a few patients lived in buildings with many other adults (multi occupancy) so that contacting them could be challenging. We saw that during a routine random audit of the practices' QOF reporting in December 2015 by an NHS England Probity Manager, they found evidence in the records to demonstrate the reasons for the exception reporting and where required these were supported by free text notes.

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

- Performance for diabetes related indicators was mainly lower than the national average. For example the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/l or less in the preceding 12 months was 70% (CCG average 79.4%, national average 77.5%). The percentage of patients newly diagnosed with diabetes, on the register, who had a record of being referred to a structured education programme within nine months after entry on to the diabetes register was 90% (CCG 95%, national average 90%). Exception reporting however for this category was low compared to the national average (practice 9%, CCG 9%, national 27%).
- Performance for mental health related indicators was generally better than the national average for example the percentage of women aged 25 or over and who had not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test had been performed in the preceding five years was 100% (CCG average 92.2%, national average 89.2%). Also the

# Are services effective?

(for example, treatment is effective)

percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding four months was 100% (CCG 95.8%, national 93.4%).

The practice had highlighted the need to improve the outcomes for their diabetic patients further. They had recently employed a diabetes specialist nurse at their sister practice in Eastbourne where there were now two nurses that could initiate advanced diabetic management. Plans were in progress to deploy a specialist diabetic team across both sites with a view to improving the outcomes of patients with the poorest control of their condition first.

The practice reported on and reviewed a significant number of key performance indicator targets relating to their contract every three months. These would include aspects such as appointment punctuality, equity of access and service delivery (cervical screening and vaccines for example). They also monitored and reported on prescribing and emergency admissions.

The work of all GPs, but particularly locums was audited by the medical services director on a regular basis. All staff were asked to feed back and comment on locum GPs. The practice would analyse and act upon the findings.

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits carried out in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Information about patients' outcomes was used to make improvements such as: adjusting the use of some inhaled medicines for some patients with respiratory conditions in line with current guidelines with the aim of reducing the prevalence of side effects.

## Effective staffing

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

- All newly appointed staff followed IC24's induction process, but the practice also had local policies for

systems and processes that were included in the induction programme. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

- All GP locums were given a comprehensive locum pack, which contained important information on practice systems, procedures and protocols.
- 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. There was a robust system employed by the provider to ensure that all staff training was up to date. A training matrix was held by the practice management locally and at head office with due dates for training for all staff. Staff were reminded of the due date well before their training was due and systems were in place to ensure that all training was completed in a timely manner.

## 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.

# Are services effective?

## (for example, treatment is effective)

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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. For example the practice were developing closer ties with the mental health team and the social prescribing team both of whom they shared a building with. The social prescribing team gave help and advice to vulnerable patients on a wide variety of social issues such as housing, debt, benefits, relationships, parenting and general wellbeing. 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. We saw that a flow chart was available to assist with assessing whether a young person was competent to make their own decisions about their health
- 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.

### Supporting patients to live healthier lives

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

- Patients with addictions to drugs or alcohol, the homeless, patients with mental health problems and those living chaotic lives, 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. Patients were signposted to the relevant service.

- Smoking cessation advice was available both from the practice team and from a local support group.

The percentage of registered women aged 25-64 with a record of cervical screening in the last five years was 71% (CCG 77%, national 77%) for 2014-2015 (source Public Health England fingertips, National General Practice profiles). These national screening survey figures were measured differently to the QOF Figures. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability, they offered translation services and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening, however the uptake of all national screening was below average despite their efforts. This was thought to be due largely to the mobile population, the high proportion of patients with English as their second language and high levels of deprivation. There were 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 lower than CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 86% to 88% (CCG 92% to 93%). Fifty six children were eligible for vaccines in this group (each child equates to just under 2%). Childhood immunisation rates for the vaccines given to two year olds ranged from 84% to 100% (CCG 91% to 97%). Fifty seven children were eligible for vaccines in this group (each child equates to just under 2%). Childhood immunisation rates for the vaccines given to five year olds ranged from 63% to 82% (CCG 90% to 96%). Thirty eight children were eligible for vaccines in this group (each child equates to just over 2.6%).

The practice recognised that these figures were lower than they would like and stressed that they made significant efforts to encourage patients to be immunised. However they felt that this was largely due to the fact that a high number of the population did not have English as their first language. They also felt that cultural diversity and the high level of deprivation affecting children (practice 35%, national average 20%) were contributing factors. They did

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

follow up patients that did not attend with phone calls and opportunistic discussions and arranged translators even when some English was spoken by the parents. They had also recently put a system in place where a mother and new born baby had an eight week check with the GP followed immediately by an appointment with the nurse for the baby's first course of immunisations.

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.

# 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.

Of the 10 patient Care Quality Commission comment cards we received eight were positive about the service experienced although five of the 10 respondents felt that the wait to be seen at the walk in centre was rather long. Patients who commented on the care that they received said they felt the practice offered an excellent service and staff were helpful, kind, caring and friendly and treated them with dignity and respect.

We spoke with one member 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 average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 90% 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%.

- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and compared to the CCG average of 92% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% 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:

- 82% 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%.
- 78% 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%.
- 88% 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:

- Thirty four percent of patients who used the practice either as registered patients or via the walk in service did not speak English as their first language. Staff told us

## Are services caring?

that translation services were available. Patients were informed that this service was available and there was a high uptake of both the telephone service and face to face translation services.

- The practice could print out information leaflets in many languages and we saw examples of registration forms in several languages.
- There was a hearing loop available for patients with hearing difficulties.
- Large print information sheets were available for patients with visual impairment.
- Leaflets were available with a map showing the location and opening times of support services for the homeless in Hastings.

### **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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had recorded 26 patients as carers (0.7% of the practice list). However the practice had identified this as a coding issue and were aware of more carers than were recorded. They were in the process of reviewing records to attempt to resolve the issue. The cared for were also identified if they were a patient. Patients that were identified as carers were referred to carer support groups if they wished to be. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, they would usually send them a sympathy card. If appropriate they would also contact the bereaved family and refer them on to bereavement support services or groups.

# 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 instance the practice were involved in lobbying for and piloting of a social prescribing centre within the health centre building which was now a commissioned service.

- The practice offered bookable appointments for their registered patients from 8am to 6.30pm daily including weekends. Registered patients could also use the walk in service from 8am to 7.50pm from Monday to Sunday.
- There were longer appointments available for patients with a learning disability or complex medical conditions.
- Telephone consultations were also available for registered patients.
- If the practice was rung from a payphone, they would ring the patient back.
- 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.
- Children using the walk in centre were seen by a nurse for assessment as a priority.
- The practice had recently introduced a text appointment reminder service.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities, baby changing facilities, a hearing loop and translation services available. Registration forms and information leaflets could be printed off in a variety of languages.
- The practice would take over the care of patients with very complex health and social concerns often via the walk in service. For example we saw that a homeless and pregnant patient accessed care via the walk in service for the first time on the afternoon of the inspection. She was seen by the GP and her acute problems addressed, social services were contacted and accommodation organised for the night, the practice

registered the patient with them and arranged an antenatal appointment the next day. The GP then phoned the clinic the next day to see if she had attended.

- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

### Access to the service

The practice was open between 8am and 8pm Monday to Sunday and access to the walk in service was available during those hours. Booked appointments for registered patients were available from 8am to 6.30pm daily including weekends. In addition to pre-bookable appointments that could be booked up to four weeks in advance, booked urgent appointments were also available for registered patients that needed them. Registered patients could also use the walk in service from 8am to 7.50pm from Monday to Sunday.

Appointments were 10 minute slots throughout the day and were designated as either for walk in patients or pre-bookable for registered patients and could be adjusted as necessary depending on demand, for instance on bank holidays, no pre-bookable appointments were available, only walk in service appointments. Posters in the waiting room explained the system as there was potential for walk in patients to think that other (registered) patients had jumped the queue. Posters also explained that patients may be seen earlier if there was concern about their condition. When walk in patients arrived, they were registered by the receptionists and details of their condition were included and put on the screen for the clinicians to see. GPs who saw both walk in and booked patients used this initial information to prioritise urgent patients, for example a young child with a temperature would be seen very quickly. Additionally receptionists would alert clinicians immediately if patients complained of symptoms on a list that they had been trained to ask about. Patients not identified as requiring urgent assessment were then seen and assessed by a nurse within an hour who recorded observations such as temperature, pulse and blood pressure before they saw the GP. Patients were seen in order of clinical need and emergencies were seen straight away, but after that patients were seen in order of arrival. Children were assessed first. Receptionists were aware of their responsibility to observe patients in the waiting room and were all aware of the signs to look for

# Are services responsive to people's needs?

## (for example, to feedback?)

that may indicate a change in a patient's condition. There was a poster next to the reception computer re-enforcing this. Reception staff told us that if they had any concerns they would alert a clinician. Additionally GPs and nurses came out to the waiting room to call patients themselves and would observe patients who were waiting. The practice put up signs to warn patients of their expected waiting time and receptionists would keep patients informed of any changes. If the expected patient waiting time reached four hours, the practice would alert the local accident and emergency department and also contact patients' own GPs if still open, to try to arrange an urgent appointment for them at their own practice.

The practice would see patients from other practices that required wound care when their practice was closed by arrangement. An appointment would be booked and the patient had to attend with a care plan and the new dressings.

The practice were contracted to see 1,500 patients not registered with the practice per month via the walk in centre. In May 2016 for example, they saw 1,579 walk in patients not registered with the practice. Additionally they saw 739 registered patients with booked appointments and 468 registered patients via the walk in centre. The practice monitored how many patients attended during each three hour time slot throughout the day and used the information to help plan staffing levels and appointment distribution. Registered patients with complex problems could book double appointments and the length of nursing appointments depended on the procedure required. Appointments could be booked face to face, online or by telephone. Telephone appointments were also available.

Figures from the Practice Performance Report for 2014 to 2015 showed the appointment punctuality figures were:

For registered patients being seen within 30 minutes of their appointment time (92%-95%).

For non registered patients being seen within two hours of arrival (98% to 99%).

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.

- 97% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 76%.

- 77% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and the national average of 73%.

We spoke to six patients on the day of the inspection, one was a registered patient with a booked appointment, two were registered patients who were using the walk in service and three were registered at other practices, but were using the walk in service. The three registered patients all thought that access to the service was very good and flexible. The two patients that were registered and using the walk in service on the day both said that it was worth the extended wait to have access to the walk in service. They also both said that their long term conditions meant that weekend access to their own GP practice was of significant benefit and had helped prevent relapses in their conditions. All three patients registered elsewhere felt that the wait was long, but that access was good.

The practice had a system in place to assess:

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

Home visit requests were put in to the next walk in appointment slot and passed to the GP. The GP phoned the patient to assess the urgency and the appropriate management.

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.
- All complaints were discussed with the individual concerned and also at monthly meetings for peer review and learning as appropriate.
- We saw that information was available to help patients understand the complaints system for example posters

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

and summary leaflets were available in the waiting room and the practice brochure and website also contained clear information regarding the complaints procedure.

We looked at 26 complaints received in the last 12 months and found that 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 to as a result to improve the quality of care. For

example, a patient complained that a member of staff had been rude and that she was unable to get an appointment on the day. The patient services manager contacted the patient and explained the appointments system to them. The patient was happy with the call and did not want a written response. Staff were reminded about the importance of their telephone manner. The complaint was also considered along with other complaints at an annual review of complaints.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision that working together their team aimed to ensure that they delivered the highest level of care possible to all of their registered and walk in patients.

- The practice had a mission statement which was displayed in the waiting areas, on the website and in the practice handbook. 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.
- Both organisational and practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- The practice had appointed a medical director and clinical nurse lead to oversee clinical governance.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

On the day of inspection the senior management in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The senior management at the practice felt well supported by the IC24 organisation. They told us they prioritised safe, high quality and compassionate care. Staff told us the GPs and managers 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). The providers 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 that the practice held regular meetings. These included clinical meetings, multidisciplinary team meetings and monthly administration meetings. The deputy practice manager attended clinical meetings and cascaded action points and learning back to the administration meetings. The nursing staff also held meetings every two months. All meetings were minuted and action points and learning fed back via email, minutes and were revisited at the next meetings.
- Staff told us there was an open, caring culture within the practice and they had the opportunity to raise any issues at meetings and felt confident and supported in doing so.
- Staff felt that everyone worked together well as part of an integrated team.
- Several social events were arranged to which all staff were invited.
- Locums were included as part of the team, taking part in the mid-morning break when the clinicians got together for 20 minutes. They were also invited to clinical meetings and emailed any alerts or policy changes directly.
- Staff said they felt respected, valued and supported, particularly by the GPs and management in the practice. All staff were involved in discussions about how to run and develop the practice, and the management team encouraged all members of staff to identify opportunities to improve the service delivered by the

# Are services well-led?

Good 

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

practice. We were told of an example by staff where the provider organisation and local management and staff were supportive following a period of absence due to sickness.

## 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 had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice carried out twice yearly patient surveys which it shared and discussed with the PPG. They also had a suggestion box in the waiting room. The PPG met every six weeks and submitted proposals for improvements to the practice management team. For example, they fed back to the practice the feelings of registered patients regarding the availability of appointments. As a response the practice listened and increased the number of appointments to book online and also opened slots bookable 48 hours in advance. They also piloted the online services such as repeat medicines, the online booking service and access to their own

medical records. They had a good relationship with the local branch of the national consumer champion for health and social care who canvassed their opinions on local health and social service provision.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. There was also a suggestion box in the staff rest room which staff were encouraged to use. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## 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. One example was the piloting of the social prescribing service in conjunction with the CCG and other practices in their building. The work of all clinical staff was audited on a regular basis to drive improvement. They were planning ways of sharing nursing specialist expertise with another walk in centre for which IC24 was the provider. They were also in discussion with the CCG regarding ways of possibly extending their services in future. They had employed a clinical pharmacist who was due to commence work shortly and were considering employing a physician's assistant.