Dartford East Health 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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

A comprehensive inspection was undertaken at Dartford East Health Centre on 28 October 2014.

Dartford East Health Centre is located in Dartford, Kent. Approximately 14,500 are registered with the practice.

During our visit we spoke with a range of staff which included four GPs. We spoke with seven patients during the inspection. We spoke to two members of the patient participation group.

We found that overall, the practice offered a good level of service to all of the patient population groups who received services from the practice.

Our key findings were as follows:

- The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. The practice was clean and medicines were managed appropriately.
- The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs have been identified and planned. However the provider may like to note that not all staff had completed an induction. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.
- The practice was rated as good for responsive, patients were happy with the current appointment system and types of appointments available. Patients said they could obtain an appointment when they needed one and they were able to get through on the telephone.
- The practice was rated as good for well led. The practice engaged patients and staff sufficiently in the

Summary of findings

operation of the service or ensured that staff had received appropriate ongoing learning and development opportunities to enable them to provide effective care, treatment and support to patients.

In addition the provider should:

- Ensure that all staff joining the practice undergo and complete induction training

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received training appropriate to their roles and further training needs were identified and planned. The practice carried out appraisals and there were personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for providing caring services. Data 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Patients were treated with kindness as well as respect and confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their individual needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Requires improvement

The practice is rated as good for being well-led. The practice had a clear vision statement and a strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures that governed activity and regular governance meeting had taken place. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with nine patients and reviewed two comment cards completed by patients prior to our inspection. All patients we spoke with during our inspection were very positive about the services they received from the practice. They told us staff were always caring, supportive and sensitive to their needs, and felt they were always treated with respect and dignity at Dartford East Health Centre.

Patients we spoke with told us the appointments system worked well for them and that they were able to get same day appointments when necessary. They said they always had enough time with the GPs and nurses to discuss their care and treatment and never felt rushed.

Patients told us they had no concerns about the cleanliness of the practice and they always felt safe there. Patients said that referrals to other services for consultations and tests had always been efficient and prompt.

There were negative comments from two patients who had completed comment cards. Both expressed dissatisfaction with the service they had received and said that staff had not listened to them.

Areas for improvement

Action the service SHOULD take to improve

Ensure that staff joining the practice undergo and complete induction training.

Dartford East Health 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 advisor and a practice manager specialist advisor

Background to Dartford East Health Centre

Dartford East Health Centre provides primary medical services Monday to Friday from 8am to 6.30pm each week and operates extended opening hours until 8pm on Tuesday evenings. The practice is situated in a suburban location in Dartford, Kent and provides a service to approximately 14,500 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the nursing team. There are a range of patient population groups that use the practice and the practice holds a general medical services (GMS) contract with the Dartford, Gravesham and Swanley area Clinical Commissioning Group. The practice does not provide out of hours services to its patients and information is available to patients about how to contact the local out of hours services provider.

The practice has one male and three female GP partners as well as two female salaried GPs. There are three practice nurses and three health care assistants also female. The practice has a number of administration / reception and secretarial staff as well as a deputy practice manager and a practice manager.

The practice has more patients in working age group than the local and national average and a higher number of children from birth up to the age of eighteen. The number of patients recognised as suffering deprivation is lower than the local and national average. The practice supports a significantly higher number of patients who have a caring responsibility than the national average.

Services are delivered from:

Dartford East Health Centre

Pilgrims Way

Dartford

Kent

DA1 1QY

Why we carried out this inspection

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

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew, including the NHS area team, the locality clinical commissioning group and the local Healthwatch.

We carried out an announced visit on the 28 October 2014. During our visit we spoke with a range of staff including GPs, nursing staff, receptionists and administration staff. We spoke with patients who used the service. We placed comment cards in the surgery reception so that patients could share their views and experiences of the service before and during the inspection visit.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we looked at processes around child protection and saw how these processes had been followed by staff and recorded in as a significant event.

We reviewed safety records and incident reports as well as minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred weekly to review actions from past significant events and complaints. There was evidence that learning had taken place and that the findings were disseminated to relevant staff. Staff, including receptionists, administrators and nursing staff, were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who used a system to monitor and manage incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. We looked at a prescribing error. The GP concerned had rectified the error and had discussed the need to double check dosages prior to issuing prescriptions at a practice meeting.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at the weekly clinical and monthly practice meetings to ensure all staff were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to alert staff for vulnerable patients on the practice's electronic records. This included information that informed staff of any relevant issues when patients attended appointments; for example children subject to child protection plans. We looked at the risk register and saw that patients identified as being at risk had alerts which were predominant when accessing their records.

The practice had a chaperone policy that was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on

child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults. Records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was followed by the practice staff, and the action to take in the event of a potential failure was described.

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

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of the directions and evidence that nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were appropriate and necessary.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead for infection control had carried out audits for each of the last two years and that any improvements identified for action were completed on time. Nurses' meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. Staff demonstrated what types of PPE they would use for different tasks such as taking blood and how they would dispose of gloves and equipment they had used. There was also a policy for needle stick injury.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and spirometry equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

Good

Are services safe?

references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting GPs and nurses and administration staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system for all the different staffing groups to ensure they was enough staff on duty. There was also an arrangement for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the practice environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. We saw records that demonstrated all staff had received training in basic life support. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment and records confirmed this was checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency involving a patient had been discussed and appropriate learning taken place.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis, epileptic fits and hypoglycaemia. Staff followed a system to regularly check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an IT company in the event of failure of the computer system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. Records demonstrated that staff were up to date with fire training and regular fire drills were undertaken by the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. Staff told us they completed thorough assessments of patients' needs in line with NICE guidance which were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease as well as asthma and that the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss best practice guidelines for the management of respiratory disorders.

We looked at data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were on appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed within one week by their GP.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with followed national standards for the referral of patients with suspected cancers to be referred and seen within two weeks of consultation. We saw minutes from meetings where regular review of elective and urgent referrals were made, and that planned improvements to practise were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of medication for patients with an elevated cholesterol test result. Following the audit the GPs carried out medication reviews and altered their prescribing practice, in line with medicines management guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information they collected for the QOF and their performance and compared them to national screening programmes to monitor outcomes for patients. For example,97% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke

Good

Are services effective?

(for example, treatment is effective)

positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The information technology (IT) system flagged relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs

Effective staffing

Personnel records we reviewed contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records. We also saw that Disclosure and Barring Service (DBS) checks (criminal records checks) had been carried out on all staff.

We saw examples of the some staff induction training although not all staff had completed this. Staff told us that they received yearly appraisals and GPs said they carried out revalidation at regular intervals. We saw records that confirmed this. There was evidence in staff files of the identification of training needs and continuing professional development.

The practice had processes to identify and respond to poor or variable practice including policies such as the management of sickness and absence policy as well as a disciplinary procedure.

Working with colleagues and other services

We were told by GPs and nurses that the practice had well established processes for multi-disciplinary working with other health care professionals and partner agencies. They told us these processes ensured that links remained effective with health visitors, community and specialist nurses, to promote patient care, welfare and safety. For example, mothers and new babies were referred to the health visitor. GPs and nurses attended multidisciplinary meetings that included community nurses, social services and the palliative care team who had specialist knowledge in long-term and complex conditions. Follow-up actions from the meetings were recorded directly into patients' electronic notes by administrative staff attending the meetings.

We were told by administrative staff that there were systems to process urgent referrals to other care / treatment services and to ensure that test results and notifications were reviewed in a timely manner once they had been received by the practice. They described the system they used to check test results and clinical information on a daily basis and how the information was shared promptly with GPs and nursing staff as a priority. The GP seeing these documents and results was responsible for the action required. Information from the 'out of hours' service was collated and distributed to GPs in the same way, with protocols for administrative staff to update patient information into the electronic records system. All the staff we spoke with understood their roles and felt the system worked well.

Information sharing

Staff told us that there were effective systems to ensure that patient information was shared with other service providers and that recognised protocols were followed. For example, there was a system to monitor patients' transition in relation to unplanned / emergency admissions to hospital. The practice received discharge notifications and these were followed-up by GPs to review and plan on-going care / treatment where required. A referral system was used to liaise with the community nurses and other health care professionals, for example, the community learning disability nurse.

An electronic patient record called "Vision" was used by all staff to coordinate, document and manage patients' care. All staff were fully trained in the use of the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how

that consent should be recorded. The policy contained examples of consent forms that patients could sign to give their consent to investigation or treatment, such as minor surgical procedures, as well as forms for patients to complete in order to withdraw any consent they had already given.

Staff told us they obtained either verbal or written consent from patients before carrying out examinations, tests, treatments, arranging investigations or referrals and delivering care. They said parental consent given on behalf of children was documented in the child's medical records. Whilst there was no evidence of formal staff training on the Mental Capacity Act 2005, staff we spoke with were able to describe how they would manage the situation if a patient did not have capacity to give consent for any treatment they required. Staff also told us that patients could withdraw their consent at any time and that their decisions were respected by the practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us three care plans that had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

There were a range of posters and leaflets available in the reception / waiting area. These provided health promotion and other medical and health related information for patients such as prevention and management of shingles as well as details of organisations that offered support to carers.

The practice provided dedicated clinics for patients with certain conditions such as diabetes and asthma. Staff told us that these clinics enabled the practice to monitor the ongoing condition and requirements of these groups of patients. They said the clinics also provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration. Patients who used this service told us that the practice had a recall system to alert them when they were due to re-attend these clinics.

Patients told us they were able to discuss any lifestyle issues with staff at Dartford East Health Centre. For example, issues around eating a healthy diet or taking regular exercise. They said that they were offered support with making changes to their lifestyle. For example, help with weight management and healthy eating.

New patients and patients reaching the age of 40 years were offered health checks. Sexual health advice was available to all patients and we saw that free chlamydia testing kits were available at the practice for patients under the age of 25 years. Services were available at the practice for patients who were experiencing problems with their memory or who were diagnosed with dementia. Cholesterol checks as well as drugs and alcohol screening were available at the practice. Staff told us that they offered appropriate opportunistic advice, such as breast self-examination and testicular self-examination, to patients who attended the practice routinely for other issues.

The practice provided childhood immunisations, seasonal influenza inoculations and relevant vaccinations for patients planning to travel overseas.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with eight patients, all of whom told us they were satisfied with the care provided by the practice. All patients we spoke with considered their dignity and privacy had been respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained whilst they undressed / dressed and during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. There was a system to allow only one patient at a time to approach each receptionist at the reception desk. Staff told us that a private room was also available at the reception desk should a patient wish a more private area in which to discuss any issues.

There were policies that governed patient confidentiality at Dartford East Health Centre. For example, the confidentiality policy for practice staff and confidentiality code of practice. There was also a confidentiality policy specifically relating to patients under the age of 18 years that guided staff and protected the rights of young people. There were information governance policies that helped maintain patient confidentiality.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. Records confirmed this and demonstrated that learning from such incidents had taken place.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance of abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they chose to receive. Patients told us they felt listened to and supported by staff and had sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive. Patient comment cards also indicated patients had sufficient time during consultations with staff and felt listened to.

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

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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received indicated that patients felt that they had been supported emotionally with their care and treatment. For example, patients said staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the practice website also signposted patients and those close to them to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to help ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us families who had suffered bereavement were called by their GP. This call was either followed by a patient consultation at a flexible time to meet the family's needs and/or signposting to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Continuity of patient care and accessibility to appointments with a GP of choice was maintained by the practice when staff changes had taken place. Longer appointments and appointments with a named GP or nurse were available for patients who needed them including those with long term conditions.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). Patients had requested that they would like to order repeat prescriptions online. The practice decided to use functionality residing in its web site for repeat prescribing and offered a service for repeat prescription requests via this route. Patients who had used the online prescription service had found it to be efficient.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients and their families care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

Tackling inequity and promoting equality

The waiting area was large enough to accommodate patients with wheelchairs and there was an area at the entrance to accommodate prams. There was easy access to the treatment and consultation rooms that were all located on the ground floor. Accessible toilet facilities were available for all patients attending the practice and there were also baby changing facilities. The practice had a hearing loop system for patients who were hard of hearing and interpretation services were available by arrangement for patients who did not speak English.

The practice took account of the needs of patients when promoting equality and considered those who may be in vulnerable circumstances. For example, working closely with the community learning disability nurse to ensure those patients with a learning disability received appropriate support and an annual assessment of their health care needs.

Access to the service

Appointments were available from 8am to 6.30pm Monday, Wednesday, Thursday and Friday, with extended hours on Tuesday from 7.30am to 8pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits as well as how to cancel appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. When patients telephoned the practice and it was closed, there was an answerphone message giving contact details of the dedicated out of hours provider where patients could access services.

Patients were generally satisfied with the appointments system. They confirmed they were able to see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice.

Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. Patients we spoke with told us that they had been seen when their need was urgent.

The practice was situated on the first floor of the building. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and there were also baby changing facilities.

The practice had a small population of non-English speaking patients and was able to cater for different languages through translation services.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their 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.

Information was available to help patients understand the complaints system in posters displayed in the waiting area, at the reception desk and on the website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at nineteen complaints received in the last twelve months and found that they had all been handled in line with the practice complaints policy.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

Requires improvement

(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 statement to deliver quality care and promote good outcomes for patients. We found details of the vision statement and practice values were part of the practice's business plan. The practice vision and values included the following aims: to offer a friendly, caring good quality service that was accessible to all patients.

Governance arrangements

The practice had a dedicated GP clinical governance lead who had received governance training. There were a variety of policies, procedures, protocols and planning documents that the practice used to govern activity. For example, the infection control policy, the chaperone procedure, the medicines storage protocol as well as the disaster handling and business continuity plan. We looked at 17 such documents and saw that all were dated within the last three years indicating when they came into use and that they were up to date. None of these documents contained a planned review date but we saw that the practice had an electronic system to ensure they were kept up to date.

Individual GPs had lead responsibilities such as safeguarding vulnerable adults and children.

We saw evidence that the practice operated a clinical audit system that continually improved the service, followed up to date best practice guidance and provided the best possible outcomes for patients. For example, a particular medicine and the monitoring of the patients taking it. We saw records that showed clinical audit results and action plans were discussed at clinical meetings and changes were re-audited to monitor any improvements.

Leadership, openness and transparency

There was a clear leadership structure with an open culture that adopted a team approach to the welfare of patients and staff. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care.

The practice demonstrated that they had not always followed their own human resources practices such as comprehensive staff induction training. The practice was unable to demonstrate that some staff were fully equipped to work safely and unsupervised when commencing their employment. We spoke with the management team who told us that induction training for certain staff had not gone ahead. Staff told us that they received yearly appraisals and GPs said they carried out revalidation with the GMC at required intervals. We saw records that confirmed this. There was evidence in staff files of the identification of training needs and continuing professional development.

Staff had job descriptions that clearly defined their roles and tasks whilst working at Dartford East Health Centre. The practice had processes to identify and respond to poor or variable practice including policies such as the management of sickness and absence policy as well as a disciplinary procedure.

Staff told us they felt well supported by colleagues and management at the practice. They said they were provided with opportunities to maintain skills as well as develop new ones in response to their own and patients' needs.

The practice was subject to external reviews, such as fire safety and infection prevention and control. GP re-verification involved appraisal by GPs from other practices.

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

The practice had gathered feedback from patients through patient surveys undertaken by the patient participation group and complaints they had received. We were shown a report on complaints received from patients, as well as an improvement report collated from the comments received from the patient survey for 2014. Where common themes were indicated, the practice had responded by making improvements and changes wherever possible, For example, online facilities had been introduced so that patients could arrange appointments and request repeat prescriptions.

The patient participation group was established and had plans to increase its membership to include 'virtual' online members. They met quarterly and had carried out annual surveys. The practice manager showed us the analysis of the most recent survey, and the improvements that had been agreed based on the findings, for example, an online facility for patients to order repeat prescriptions.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they

Are services well-led?

Requires improvement

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

were confident and felt supported to give feedback and discuss any concerns or issues with colleagues and management. They also described some of the suggestions they had made to make improvements for patients, for example, telephone lines in the office behind the reception area to help improve confidentiality and we saw this had been acted on. Staff said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle-blowing policy which was included in the staff handbook and was available to all staff electronically on any computer within the practice. Staff we spoke with told us they knew where to find the policy and would use the process if necessary.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training sessions where guest speakers and trainers attended.

The practice valued learning. There was a culture of openness to reporting and learning from patient safety incidents. All staff were encouraged to update and develop their knowledge and skills.

We saw that the practice had a system to investigate and reflect on incidents, accidents and significant events that occurred. All reported incidents, accidents and significant events were managed by dedicated staff. Feedback from investigations was discussed at weekly clinical meetings and relevant information was shared at wider staff meetings.

The practice had systems to identify and reduce risk. Risk assessments were carried out and where risks were identified action plans were made and implemented in order to reduce the identified risk. This activity was monitored in order to evaluate the effectiveness of the implemented action plan.

We saw records that demonstrated equipment such as blood pressure monitors and blood glucose testing equipment were regularly serviced and calibrated. The practice's fire risk assessment was up to date and there was contingency planning contained in the business continuity plan to manage risks, for example, loss of the computer system. On going health and safety risk assessments were carried out in accordance with the practice's health and safety policy.