Dr Jasjeet Dua

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.

Summary of findings

Contents

Summary of findings

Overall summary

Dr Jasjeet Dua provides primary care services at Kensington Park Medical Centre in West London. The practice provides care to a diverse local community of approximately 6500 patients. Services provided include antenatal care, child health and immunisation, sexual health, chronic disease management and end-of-life care. The practice is registered with the Care Quality Commission to provide the following regulated activities: diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures; and, treatment of disease, disorder or injury.

We collected 23 comment cards that patients had completed in advance of the inspection visit and spoke with five patients attending the practice on the day of the inspection. All the patients who gave feedback were happy with the quality of care they received and many praised individual staff members.

The practice provided a safe service with systems in place to manage risks associated with infection control, medicines management, staff recruitment, child protection and adult safeguarding and medical emergencies. There were mechanisms to investigate and learn from incidents and complaints.

Patients' needs were assessed and treatment and referral patterns were in line with current guidelines and best practice. Staff participated in collaborative clinical audits and external peer group meetings and used this evidence to improve. Staff were encouraged to develop their professional practice and skills and received an annual appraisal. The lead GP

Patients told us the practice was caring. Patients who participated in the inspection were happy with the service they received at the practice. They said they were involved in decisions about their treatment. We observed that reception staff were polite and respected patients' privacy. The practice operated a chaperone service but had not yet trained staff acting as chaperones on this role.

The practice was responsive to the needs of its patients. The practice provided services tailored to particular patient groups and routinely booked interpreters for patients who did not speak English as a first language. The practice had explored different ways for patients to access the service and patients told us they did not usually have difficulties making an appointment when they needed one. The practice promoted health and the prevention of illness with written information in the waiting room, services such as smoking cessation advice and targeted advice for patients with particular health conditions.

The practice ethos was to put patients first and provide a high quality service. There were governance arrangements in place and an open reporting culture. Staff members told us they benefitted from excellent clinical and managerial leadership within the practice and said this had a positive impact on the quality of care. The practice obtained feedback from patients through surveys, informal feedback and complaints and used this to improve the service. However, the practice did not have a patient participation group.

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 learned from incidents to improve the safety of the service. Lessons learned were discussed at the weekly clinical team meeting and followed up with changes to practice if appropriate. There were enough qualified and experienced staff to meet the needs of patients. The practice had safe recruitment procedures and carried out all necessary pre-employment checks before new staff members started to work at the practice.

The staff were aware of procedures to protect children and vulnerable adults from the risk of abuse and they raised any concerns without delay.

The practice was clean and well equipped and there were systems in place to reduce the risk and spread of health acquired infection. The practice nurse was the lead for infection control and carried out audits of infection control. Medicines were managed safely. Staff were trained to respond to medical and other emergencies.

Are services effective?

Patients' needs were assessed and treatment and referral was in line with current guidelines and best practice. The practice worked in collaboration with other health and social care professionals to provide integrated patient care.

There were appropriate arrangements in place to monitor review, and improve performance. The practice participated in audit, external peer group meetings and used this evidence to improve.

The staff received an annual appraisal and revalidation as required. The practice promoted health and prevention and provided patients with information, advice and guidance.

Are services caring?

Feedback from patients for the inspection was universally positive about this aspect of the service. Individual doctors and nurses were singled out for praise by several patients. The practice's own patient survey of over 100 patients also showed that patients were happy with the way they were treated.

Patients told us they had been involved in decisions about their care. The doctors and nurses obtained patients' consent to treatment and respected their wishes. We saw that staff took care to respect patients' privacy. The receptionists were aware that they might be asked to act as chaperones but had not received any training on what this involved.

Summary of findings

Staff were aware of their responsibilities under the Mental Capacity Act 2005. The practice had systems in place to alert doctors to patients' advance directives where these were in place.

Are services responsive to people's needs?

The practice had identified sexual health, alcohol use and mental health as local areas of need in discussion with the local NHS commissioning bodies.

There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met. Patients were able to access appointments when they needed them.

The practice routinely booked interpreters for patients whose first language was not English and provided a chaperone service. Written information tended to only be available in English. The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Are services well-led?

The practice ethos was to treat patients as individuals and provide high quality care. The staff had clearly defined roles and responsibilities and were positive about the quality of leadership and support they received.

There were governance arrangements to monitor risk and performance and an open reporting culture. Mechanisms for learning and improvement including collaborative team meetings, clinical audit, incident reporting and learning from patient feedback were embedded in the running of the service.

The practice was aware of risks to the business and took these into account in its policies and planning.

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 was responsive to the needs of older patients and carers. The practice routinely offered people over 75 a health check in line with national guidance and encouraged older patients to have the flu vaccination. The doctors carried out home visits to frail older patients and carers when appropriate and were familiar with these patients' individual circumstances and needs. The practice supported continuity of care for people with long term or complex conditions and people coming to the end of life.

People with long-term conditions
The practice had effective systems in place to care for patients with long term conditions and was performing well in relation to relevant national and local targets. The practice provided support to enable patients to manage long-term conditions themselves effectively and ran various condition-specific clinics.

Mothers, babies, children and young people
The practice offered a range of services for mothers and babies and was meeting national targets in relation to primary care services for children. Staff understood their responsibilities in relation to safeguarding children and acted when they had concerns.

The working-age population and those recently retired
The practice operated with extended opening hours on two evenings a week and had experimented with different appointment and access options. The practice served a relatively young and mobile population. The practice recognised the health needs of working age people and had developed its services in response.

People in vulnerable circumstances who may have poor access to primary care
The service was available to patients regardless of their individual circumstances. The practice used its computerised records system to flag risk factors for individual patients.

People experiencing poor mental health
The practice provided care to people experiencing poor mental health. Several of the doctors had a 'special interest' in mental health and were knowledgeable about local community, specialist and assessment services.

Summary of findings

What people who use the service say

We reviewed information the practice's own patient feedback survey which included interviews with over 100 patients, and interviews and comments we obtained from patients during the inspection.

Patients were very happy with the service they received at the practice and commented positively on individual members of staff. They said they were fully involved in decisions about their treatment and were not rushed by the doctors or nurses. One patient we spoke with had experienced the referral process and said this had run very smoothly and they knew what to expect.

Patients said the premises were clean and well equipped and we observed this to be the case on the day of our inspection. Nine out of ten patients responding to the practice's own survey said they would recommend the practice to others. The practice scored in the top 25% of practices nationally for the proportion of patients who described the service as good or very good.

Patients said they could usually obtain an appointment with the doctor of their choice and they were usually seen for their appointment on time. The lead GP told us they had increased the number of walk-in appointments and telephone consultations which had helped to make the service accessible to patients.

Areas for improvement

Action the service COULD take to improve

The service:

- did not have a patient participation group to provide rich, targeted patient feedback;
- had not trained its receptionists on how to chaperone patients.

Dr Jasjeet Dua

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector**.** The team included a GP, a second CQC inspector, and an "expert by experience". They were all granted the same authority to enter the Kensington Park Medical Centre as the CQC inspectors.

Background to Dr Jasjeet Dua

Dr Jasjeet Dua provides primary care services from the Kensington Park Medical Centre to around 6500 people living in the surrounding areas of Hammersmith and Kensington in West London. The practice population is ethnically, culturally and socioeconomically diverse. It is also characterised by a relatively small older population and a high proportion of people moving into and out of the area. The practice is open Monday to Friday with extended opening hours on two evenings a week. Services provided include antenatal care, child health and immunisation, sexual health, chronic disease management and end of life care. The practice maintains a practice website with details of opening times, the staffing team and services provided.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 20 May 2014. During our visit we spoke with a range of staff (the lead GP partner, a salaried GP, the practice manager, the practice nurse, the health care assistant, and a receptionist) and spoke with patients who used the service. We also observed the physical environment and attended part of the doctors' weekly clinical meeting.

Are services safe?

Summary of findings

The practice learned from incidents to improve the safety of the service. Lessons learned were discussed at the weekly clinical team meeting and followed up with changes to practice if appropriate. There were enough qualified and experienced staff to meet the needs of patients. The practice had safe recruitment procedures and carried out all necessary pre-employment checks before new staff members started to work at the practice.

The staff were aware of procedures to protect children and vulnerable adults from the risk of abuse and they raised any concerns without delay.

The practice was clean and well equipped and there were systems in place to reduce the risk and spread of health acquired infection. The practice nurse was the lead for infection control and carried out audits of infection control. Medicines were managed safely. Staff were trained to respond to medical and other emergencies.

Our findings

Safe patient care

The practice had systems in place to identify and learn from patient safety issues. The number of safety incidents was low but when incidents had occurred, we saw evidence that the practice investigated them. There were written operating procedures covering areas of risk including infection control, incident reporting, safeguarding, staff recruitment and medicines management. These were readily available to view. The staff we spoke with were familiar with practice procedures and how to access written policy and procedures if they wanted to refer to these. The practice computer system was used to alert doctors of particular risks and issues for example, patient allergies or when a medication review was due.

Learning from incidents

There were arrangements in place for reporting safety incidents. The practice held weekly clinical meetings which were attended by the clinical staff and the practice manager. Incidents or complaints were documented and discussed at these meetings. The practice manager captured the learning and ensured actions were followed up. There was also an annual meeting at which the outcome and learning from incidents was collated and reviewed. Clinical and administrative staff told us there was an open reporting culture within the team. We observed part of the weekly clinical meeting and saw that staff were comfortable discussing and reflecting on their practice and learning from incidents.

All the staff members knew how to report safety incidents, “near misses” and significant events. The practice manager provided us with an analysis of incidents and significant events from the previous year. This included a case where a patient had been unable to access a doctor in a timely way causing anxiety and they had complained. We saw evidence that the incident had been investigated and learning points documented and shared with staff and fed back to the patient. The practice had implemented changes to reduce the risk of reoccurrence.

Safeguarding

There were arrangements in place for reporting allegations of abuse in line with national and statutory guidance. Staff members were trained on safeguarding children and vulnerable adults with the GPs trained to level three on

Are services safe?

child protection. Two members of reception staff had been recently appointed and were in the process of being booked onto training. In the interim, they had had a safeguarding training session with one of the doctors. Staff understood their responsibility to report concerns and the importance of doing so without delay.

Safeguarding concerns were discussed at the weekly clinical meeting. We saw evidence from the minutes of these meetings and observing part of one meeting that staff recognised and reported concerns about potential abuse and neglect. We discussed a number of recent cases with members of staff. The doctors shared information of concern with community health teams and social services when appropriate.

Monitoring safety and responding to risk

The staff we spoke with understood the risks associated with the provision of primary care services. The practice had developed policies to ensure that staff knew how to respond to risks including management of medicines, infection control, safeguarding and repeat prescribing. The practice used the weekly clinical team meetings to monitor and respond to risk. Medical alerts, including drug recalls, were circulated to all doctors by the practice manager.

The practice had developed a business continuity plan to cover risks to the day-to-day running of the service. We were told that the practice had recently experienced a temporary failure of its internet and telephone systems. The continuity plan had been put into action effectively, for example, the electronic appointment system had been backed up, and patient care had not been compromised. This incident had been reviewed for learning and the practice had obtained an additional mobile phone as a result.

Medicines management

The practice stored medicines safely including vaccines, stock medicines and patients' own medicines. The practice ensured that the correct temperature was maintained for the storage of temperature-critical medicines. There were set procedures for staff to follow should the fridge temperature deviate from the accepted range and put the integrity of stored vaccines at risk. The practice nurse checked the stock of emergency medicines quarterly and fridge temperatures daily. The practice was visited by the local NHS medicines management team every six months. The practice had a policy and procedures to manage repeat prescribing safely.

Cleanliness and infection control

Patients said the environment always seemed clean. The practice had an infection control lead, and a written policy and procedures. Procedures covered effective hand washing, the use of personal protective equipment such as disposable gloves and the safe disposal of clinical waste and sharps. The premises were suitably adapted and equipped to provide medical treatment including minor surgery. The premises were cleaned daily to a set schedule and clinical waste disposed of appropriately.

The practice nurse was the infection control lead and had completed an audit of infection control within the previous six months. The results were generally positive but the nurse had found some areas for improvement, for example, better cleaning of computer keyboards. The nurse had repeated the survey to check that practice had improved.

Staffing and recruitment

We reviewed the staff recruitment process and looked at a number of documents which confirmed recruitment checks had been carried out. The practice had undertaken all necessary pre-employment checks including evidence of professional registration, criminal records checks and satisfactory references for both permanent and locum members of staff. We saw the guidance pack provided to locum doctors included information about practice policy and procedures, local services, referrals and contacts. Two members of reception staff had started to work very recently at the practice. They both confirmed they had received a good induction into practice policies.

There were enough qualified and experienced staff to meet the needs of patients. The practice was staffed by the lead GP partner and four salaried GPs. One GP was on leave at the time of inspection and their post was being covered by a locum GP. The practice employed a part-time practice nurse, a health care assistant, administrative and reception staff and a practice manager.

Dealing with Emergencies

The practice was equipped with a defibrillator and medicines for use in medical emergencies. The practice nurse checked the emergency equipment weekly to ensure it was ready for use. Staff were trained in basic life support annually and knew where the emergency equipment was located.

Are services safe?

Equipment

The practice was well equipped to provide primary care services. The practice kept maintenance and service logs for medical equipment such as the blood pressure monitors. Portable appliance testing was carried out on electrical items. The practice used disposable supplies where appropriate.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients' needs were assessed and treatment and referral was in line with current guidelines and best practice. The practice worked in collaboration with other health and social care professionals to provide integrated patient care.

There were appropriate arrangements in place to monitor review, and improve performance. The practice participated in audit, external peer group meetings and used this evidence to improve.

The staff received an annual appraisal and revalidation as required. The practice promoted health and prevention and provided patients with information, advice and guidance.

Our findings

Promoting best practice

Best practice standards and guidelines were followed in the assessment and planning of patients' healthcare needs. The practice met nationally agreed targets and benchmarks, for example as measured by the General Practice Outcome Standards (a set of London-wide quality and safety standards developed by experts including GPs, academics and commissioners). Staff were encouraged to keep their professional skills and knowledge up-to-date. Doctors in the practice had developed their areas of clinical interest to include dermatology, sexual health and minor surgery and the practice nurse was studying for a qualification in family planning.

The clinical staff were aware of and followed national guidelines for treatment and prescribing. Unusual or exceptional cases were reviewed at the weekly clinical meeting or authorised by one of the experienced GPs. The practice followed national and locally agreed policies for referrals, for example, referring patients with cancers within two weeks. The practice had electronic referral templates. This assisted the doctors, including locum staff, to obtain and assess the information needed to make a referral to the appropriate specialist.

Management, monitoring and improving outcomes for people

The practice was meeting most national and local targets for the management of a range of chronic conditions and had performed well on the Quality and Outcomes Framework (QOF) in 2013. The Quality and Outcomes Framework is part of the national GP contract. Under the QOF, GP practices are rewarded for achieving various targets related to good practice.

The practice took part in local commissioning group and peer group meetings to benchmark performance data and share good practice across local practices. This included work on inappropriate outpatient referrals, avoidable A&E attendances and emergency admissions.

The practice undertook clinical audits required to meet various QOF targets, enhanced service targets and participated in audit and benchmarking exercises organised collaboratively by the clinical commissioning group. Individual GPs had undertaken audit as part of the revalidation and appraisal process.

Are services effective?

(for example, treatment is effective)

The practice used clinical audit to monitor and improve the quality and safety of the service. For example one doctor showed us an audit of the use of a medicine which was not considered a "first line" treatment to check this was being prescribed appropriately.

Staffing

The practice manager monitored demand by reviewing the appointment system. They were able to adjust the staffing levels if demand was unexpectedly high, for example, by securing additional locum doctor support. The practice was in the process of securing increased practice nurse sessions in response to patient demand. The GP partner had successfully undergone revalidation. All the doctors had received an annual appraisal in line with professional requirements. All other staff received an annual appraisal which was organised internally.

Working with other services

The practice worked effectively with other services. There were clear referral pathways. The practice referred patients to a wide range of specialist services which were available in the local area. These included physiotherapy and the community psychiatric liaison nurse who were based in the same building.

Staff described positive relationships with community health professionals, for example, the local health visitors and community nurses. The doctors were able to obtain telephone advice from a range of hospital specialists prior to making a referral. We were told this was particularly helpful for paediatric referrals. The doctors ran monthly multidisciplinary team meetings to review the progress of patients with complex needs and adjust care plans as required. These were attended by practice staff, community and specialist professionals as appropriate.

Health, promotion and prevention

The practice promoted patient's health and wellbeing. There was a wide range of posters and leaflets in the waiting area and a television which displayed information about exercise and diet. Written information tended to be available only in English. The practice participated in national population and child health screening and immunisation programmes and monitored coverage rates. The practice also offered chlamydia screening for younger adults under its Personal Medical Services contract.

The doctors and practice nurse provided targeted health promotion advice during consultations. The health care assistant's role included health promotion and they provided health checks and advice for patients on lifestyle factors such as smoking cessation and diet. The practice ran a range of clinics for patients with particular conditions, for example, diabetes. Staff provided patients who attended these clinics with information about maintaining their health and managing their condition to reduce the risk of complications.

Are services caring?

Summary of findings

Feedback from patients for the inspection was universally positive about this aspect of the service. Individual doctors and nurses were singled out for praise by several patients. The practice's own patient survey of over 100 patients also showed that patients were happy with the way they were treated.

Patients told us they had been involved in decisions about their care. The doctors and nurses obtained patients' consent to treatment and respected their wishes. We saw that staff took care to respect patients' privacy. The receptionists were aware that they might be asked to act as chaperones but had not received any training on what this involved.

Staff were aware of their responsibilities under the Mental Capacity Act 2005. The practice had systems in place to alert doctors to patients' advance directives where these were in place.

Our findings

Respect, dignity, compassion and empathy

Patients described the service as very caring. Patients said they were always treated kindly and with respect by the staff. We received 23 comment cards from patients and all of them praised the service. Several patients commented about the quality of individual members of staff. The practice's own patient survey was completed by over 100 patients in October 2013. Over 90 per cent of respondents said they would recommend the practice to others. The national patient survey 2013 echoed these findings with 95.7 per cent of respondents describing the service as good or very good.

During the inspection we saw patients being greeted politely by the staff. When patients arrived with questions or issues we saw that the staff took the time to ensure these were resolved.

The practice protected patients' privacy. The seating area was located away from the reception desk insofar as possible. There was a second waiting area and rooms which could be used if a patient needed to speak in private. There was no written notice informing patients that this was possible however. Receptionists took care not to repeat patients' date of birth or discuss confidential information over the phone in a way that would allow others to identify the person. Consultation rooms were located well away from the reception and consultations were conducted with the door closed and could not be overheard. Staff ensured that confidential information was not openly visible to others. Access to clinical areas was restricted and could not be entered without a pass. The practice offered a chaperone service. The receptionists were aware that they might be asked to act as chaperones but had not received any training on what this involved.

The practice supported continuity of care for patients with long term or complex conditions, older people and carers and patients coming to the end of life.

Involvement in decisions and consent

Patients told us they had been involved in decisions about their treatment and had time to ask questions. They said they had been given useful information and any treatment

Are services caring?

had been fully explained to them. One doctor told us they found it rewarding when patients became more engaged in their care and this also made it more likely they would comply with a course of treatment.

Clinical staff sought verbal consent from patients, including children, before conducting examinations. Verbal consent was also sought before treatment, referral or immunisation. The practice required written consent for some procedures, such as minor surgery and had consent forms for this.

The practice did not have a Patient Participation Group (PPG). A PPG is a group made up of practice patients who provide feedback on the service. PPGs can help practices to obtain a deeper understanding of patients' needs and experiences of the service. The practice manager told us they were in the process of setting up a group but it had been difficult in the past to get patients interested and involved.

Clinical staff were aware of their responsibilities under the Mental Capacity Act 2005. Some patients had made advance directives about their future care. Advance directives are useful in the event of a person subsequently losing the capacity to make decisions about their care, for example following a diagnosis of dementia. The practice computer system alerted doctors when a patient had made an advance directive so their wishes were not inadvertently overlooked.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had identified sexual health, alcohol use and mental health as local areas of need in discussion with the local NHS commissioning bodies.

There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met. Patients were able to access appointments when they needed them.

The practice routinely booked interpreters for patients whose first language was not English and provided a chaperone service. Written information tended to only be available in English. The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Our findings

Responding to and meeting people's needs

Patients we spoke with and who completed comments cards said the practice met their healthcare needs. This was echoed in the practice's own patient survey conducted in February 2014.

The practice provided a service to a diverse population with a wide range of needs. The practice provided an enhanced range of services through a "Personal Medical Services" contract with NHS England to meet identified local needs. The practice had a relatively high proportion of younger adults on its patient list and had identified sexual health needs, alcohol use and mental health as being local issues following discussion with the local commissioning team. The practice had also identified a relatively high rate of termination of pregnancy in the local area and was exploring ways the service might help to reduce the incidence of unwanted pregnancies, for example by offering a wider range of contraceptive options.

Access to the service

We received positive feedback from most patients about access to the service. The practice carried out home visits to patients to frail or unwell to attend the surgery. The practice did not provide services out-of-hours. Patients were able to attend 'walk-in' clinics at a number of other local practices at the weekend or use the '111' urgent care telephone service.

We were given examples of how the practice had explored ways to improve the productivity and accessibility of the clinical team. For example by increasing the number of telephone consultations and having a number of walk-in appointments available each day. Two patients commented that they had to wait several weeks to book an appointment with the practice nurse for blood tests. The practice was in the process of increasing the number of practice nurse sessions.

Many patients who used the service did not speak English as a first language. The practice could provide an interpreter for patients who needed help with any communication needs and we observed a receptionist offering this facility to patients. One of the doctors spoke Farsi and we were told that some patients registered with the practice valued this.

Are services responsive to people's needs?

(for example, to feedback?)

The practice was accessible to patients with mobility difficulties.

Concerns and complaints

The practice had a complaints process. Complaints were documented, investigated and discussed in the weekly clinical meeting. We reviewed a complaint the practice had recently received. This had been managed in line with practice policy. The person making the complaint was kept informed about the investigation and the outcome. We saw that letters to complainants included an apology and an explanation when a complaint had been upheld.

Are services well-led?

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

Summary of findings

The practice ethos was to treat patients as individuals and provide high quality care. The staff had clearly defined roles and responsibilities and were positive about the quality of leadership and support they received.

There were governance arrangements to monitor risk and performance and an open reporting culture. Mechanisms for learning and improvement including collaborative team meetings, clinical audit, incident reporting and learning from patient feedback were embedded in the running of the service.

The practice was aware of risks to the business and took these into account in its policies and planning.

Our findings

Leadership and culture

The GP partner was the clinical and corporate lead for the practice and was supported in this role by the practice manager. There were clear management arrangements and staff knew who led on particular issues such as infection control and safeguarding. Staff members praised the leadership provided by the lead GP and the practice manager and they said this had a positive impact on the service. The team culture was described as open and supportive. Staff were encouraged to develop professionally and were supported in their roles. For example, the practice nurse told us she had a regular mentoring session with the lead GP which had increased her confidence and skills.

Governance arrangements

The practice had governance arrangements in place. Assurance for quality and safety was the responsibility of the GP partner and managed through the weekly clinical meetings which covered incidents, audits, complex cases, complaints, safeguarding and other monitoring information. The practice kept clear written supporting documentation on incidents, audit and other performance information. The practice provided regular contract monitoring reports on aspects of performance to NHS England.

Systems to monitor and improve quality and improvement

The practice understood how it performed across a range of patient outcome measures compared to other local practices. The practice participated in local NHS meetings to discuss and compare performance in the area. The practice also participated in shared data quality and auditing exercises, for example on prescribing and took account of the results.

The clinical staff had been involved in auditing and monitoring aspects of their care. Audits were reviewed to determine the practice had taken improvement action when indicated. The practice used the computer records system to support monitoring and audit reporting.

Patient experience and involvement

Patient feedback about the service was positive. This was obtained through an annual patient survey and individual comments, complaints and compliments. The practice did

Are services well-led?

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

not have a patient participation group however. We were told the practice manager had tried to set this up in the past but patient interest had been low. There was a poster displayed in the waiting room asking patients if they would be interested in joining a patient participation group and explaining what this would involve.

Staff engagement and involvement

Staff were engaged through regular meetings and discussion. The doctors completed an annual appraisal. The nursing and administrative staff also received an appraisal and there were regular meetings for all staff. We saw the minutes which showed that all staff had contributed to discussions.

Learning and improvement

The practice demonstrated that it learnt from incidents, complaints and patient feedback. We also saw evidence that it responded to clinical guidance and research, national safety alerts, analysis of its performance and legislative requirements. The main internal mechanism for change was through staff meetings and collaborative action planning. The practice manager also routinely collated various forms of evidence such as audit reports, complaints and incidents and shared this with staff.

Staff said the GP partner and practice manager were positive about change and that influenced the whole team and the working culture at the practice. Staff could identify changes the practice had made to improve care and outcomes for patients, such as additional services.

Identification and management of risk

The practice was aware of risks to the business. The practice had developed a business continuity plan and a range of policies and procedures which covered various risks, such as fire safety and information governance. The GP partner was planning for the longer-term development and expansion of the practice, for example, mentoring staff members to develop clinical leadership skills in the team.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice was responsive to the needs of older patients and carers. The practice routinely offered people over 75 a health check in line with national guidance and encouraged older patients to have the flu vaccination. The doctors carried out home visits to frail older patients and carers when appropriate and were familiar with these patients' individual circumstances and needs. The practice supported continuity of care for people with long term or complex conditions and people coming to the end of life.

Our findings

The practice was responsive to the needs of older patients and carers. The practice routinely offered patients over 75 a health check in line with national guidance, a named GP and encouraged older patients to have the flu vaccination. The doctors carried out home visits to frail older patients and carers when appropriate and were familiar with these patients' individual circumstances and needs.

Some older patients told us that continuity of care was very important to them. They said they were usually able to see their doctor of choice at the practice which was beneficial. The practice encouraged continuity of care for patients with long term or complex conditions and patients coming to the end of life.

The doctors gave us examples of how they tailored their care and approach to different individuals. For example, inviting one older person for a health check when the doctor had concerns about a change in this patient's social circumstances.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice had effective systems in place to care for patients with long term conditions and was performing well in relation to relevant national and local targets. The practice provided support to enable patients to manage long-term conditions themselves effectively and ran various condition-specific clinics.

Our findings

The practice had effective systems in place to care for people with long term conditions. The practice was meeting national and local targets for the management of a range of chronic conditions and the nurse ran various condition-specific clinics. The GPs had “special interests” and additional training in a range of long term conditions including asthma, dermatology, mental health and diabetes. Support was given to patients to help them manage these conditions effectively themselves.

Clinical staff were alerted electronically or by the practice manager to relevant national clinical guidelines and updates. The practice operated a “case management” system for patients with complex needs in the local community. These patients were reviewed at a monthly multidisciplinary team meeting. The meeting was attended by practice staff, local community health staff and specialists with the aim of meeting patient’s needs in the community and avoiding hospital admissions where possible.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice offered a range of services for mothers and babies and was meeting national targets in relation to primary care services for children. Staff understood their responsibilities in relation to safeguarding children and acted when they had concerns.

Our findings

The practice was meeting national immunisation targets in relation to primary care services for children. The practice provided offered ante-natal care in partnership with the local hospital. The practice also offered a weekly walk-in baby clinic which was run by the community health visitors.

The doctors used guidelines to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate.

All staff were aware of child protection and safeguarding procedures. The practice was able to demonstrate that staff had taken action when they had concerns about potential abuse and child neglect to protect children from harm.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice operated with extended opening hours on two evenings a week and had experimented with different appointment and access options. The practice served a relatively young and mobile population. The practice recognised the health needs of working age people and had developed its services in response.

Our findings

The practice population was characterised by a high proportion of working age adults. The practice had experimented with different appointment and access arrangements in order to make the service readily available to working people. The practice operated with extended opening hours two evenings a week and it was possible to access the doctors through telephone consultations. The practice did not yet offer online appointments which this group of patients might find convenient.

The practice had identified health needs associated with a younger population. For example it had developed its sexual health and family planning services. The practice had identified a relatively high rate of termination of pregnancy in the local area and was exploring ways the service might help to reduce the incidence of unwanted pregnancies, for example by offering a wider range of contraceptive options.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The service was available to patients regardless of their individual circumstances. The practice used its computerised records system to flag risk factors for individual patients.

Our findings

The practice served a diverse population including people in vulnerable circumstances. The practice had a policy of never turning new patients away regardless of their circumstances. The practice served homeless families staying in nearby temporary housing. Staff told us they were committed to providing good care to patients whatever their circumstances.

The practice used its computerised records system to flag risk factors for individual patients, for example, children assessed as being “at risk” by social services professionals. This meant that staff were automatically alerted by the computer system when the patient visited the practice.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice provided care to people experiencing poor mental health. Several of the doctors had a “special interest” in mental health and were knowledgeable about local community, specialist and assessment services.

Our findings

The practice had identified mental health as a priority given the prevalence of mental health needs in the local area. Several of the doctors had a “special interest” in mental health and were knowledgeable about local community, specialist and assessment services. Patients were referred and signposted to specialist community mental health care for assessment and treatment when indicated and were able to self-refer to counselling services. Information on support services for mental health problems was displayed in the waiting room.