

The Hamilton Practice

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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

On 14 October 2014 we conducted an announced comprehensive inspection of The Hamilton Practice.

We found the practice overall rating was Good, improvements were required under the safe domain but all other domains, effective, responsive, caring and well led were rated as good.

Our key findings were as follows:

We found the practice had a clear strategy and a plan regarding how this was to be delivered.

- We found the practice treated patients with compassion, dignity and respect. They were involved in care and treatment decisions and were provided accessible information to help them understand the care available to them.
- 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 needs.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure appropriate professional advice is responded to e.g. reports from the Clinical Commissioning Group pharmacist on prescribing.
- Systems must be put in place to ensure patient dressings supplied for their individual use should be in date and stored separately from practice supplies.

In addition the provider should:

- Ensure that completed clinical audit cycles are collated and learning shared within the practice.
- Clinical staff should be provided with the opportunity to have individual clinical supervision.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for safe as there are areas where improvements should be made. Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated widely enough to support improvement. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. We found the practice had not reviewed patients' medicines when risks identified by a pharmacist were brought to their attention.

Requires improvement



Are services effective?

The practice is rated as good for effective. GPs took personal responsibility for their adherence to National Institute of Health and Care Excellence (NICE) guidance and used it routinely. People's needs were assessed and care planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned for. The practice conducted appraisals and had personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. 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. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. 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 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.

Good



Summary of findings

Are services well-led?

The practice is rated as good for well-led. The practice had a vision and a strategy to deliver it. However, not all staff were aware of this and their responsibilities in relation to it. There was a leadership structure documented and most staff felt supported by management and their colleagues. The practice had a number of policies and procedures to govern activity and these were supported by regular and well documented meetings. The practice was responsive to feedback from patients and staff. Staff received inductions, regular performance reviews and attended staff meetings and time to learn training events.

Good



Summary of findings

What people who use the service say

We spoke to patients on the day of our inspection and reviewed four comment cards completed by people who attend the surgery ahead of our visit. All regarded the practice as good, very good or excellent and told us that the staff were polite and helpful and the surgery was safe clean and tidy. Patients appreciated the attendance of the phlebotomy service from Princess Alexandra Hospital

and found the clinical team listened and responded to their needs. (Phlebotomy is the act of drawing or removing blood from the circulatory system through a cut (incision) or puncture in order to obtain a sample for analysis and diagnosis. Phlebotomy is also done as part of the patient's treatment for certain blood disorders).

Areas for improvement

Action the service **MUST** take to improve

- Appropriate professional advice must be responded to e.g. reports from the Clinical Commissioning Group pharmacist on prescribing.
- Systems must be put in place to ensure patient dressings supplied for their individual use are in date and stored separately from practice supplies.

Action the service **SHOULD** take to improve

- Ensure that completed clinical audit cycles should be collated and learning shared within the practice.
- Clinical staff should be provided with the opportunity to have individual clinical supervision.

The Hamilton Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a GP and practice manager.

Background to The Hamilton Practice

The Hamilton Practice is located on the borders of Essex and Hertfordshire and provides services for approximately 9,500 patients living in the area. It is situated in a shared purpose built medical centre used by another GP practice of similar size and has on-site community nursing facilities. The practice benefits from a number of specialist services based within the same building, such as the health visitors, a midwifery service providing mother and baby care, physiotherapist and dietician.

Parking on site is restricted to staff and two spaces for people with disabilities. A public car park is situated opposite the practice.

The Hamilton practice is a training practice and encourages and facilitates the training of GPs. There are six partners, one salaried GP, two nurses and three health care assistants. There were two trainee GPs working at the practice at the time of our inspection.

We looked at the practice website. It provided patients with information on a range of clinics, such as child immunisation, antenatal, child health surveillance, health promotion (anti-smoking, weight reduction, diabetes and well person checks).

The Hamilton Practice is open from 8am to 6.30pm and an early surgery is offered on a Friday from 7.30am. All patients

require appointments prior to attending. A duty doctor scheme operates where a patient can see a doctor by prior appointment made up to 48 hours in advance and also provides emergency cover throughout the day from 8am to 6.30pm. The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed.

The practice has applied to NHS England for funding for an additional consultation room.

Why we carried out this inspection

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

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

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?

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We also reviewed information we had requested from the provider and information available in the public domain.

We carried out an announced visit on 14 October 2014. During our visit we spoke with a range of staff including GPs, reception staff, practice manager and administrative staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients, where appropriate.

We reviewed four CQC comment cards completed by patients who had shared their views and experiences of the service. We also looked at the practice facilities, equipment and medications kept on the premises.

Are services safe?

Our findings

Safe Track Record

We found the practice had clear lines of accountability and responded appropriately to safety concerns by the staff and patients. These were reported to the practice manager who investigated them with the clinical team and provided a response. Wider learning from incidents was shared with the staff.

We found there were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The practice nurse and health care assistant were responsible for reviewing and disseminating information to staff. The alerts contained safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We reviewed meeting minutes that were clear and comprehensive where issues were discussed with all staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant or untoward events such as medication errors. We reviewed the practices' records and found investigations had been conducted and the findings disseminated, in a timely manner as part of clinical meetings. Where the practice had contributed to a serious case review this was known amongst the staff who had been fully engaged in the investigation and shared learning from the findings.

We asked the practice how they maintained their knowledge base and ensured they learnt from local and national recommendations such as from serious case reviews, coroner's rulings or safety alerts. They told us they regularly attended Clinical Commissioning Group (CCG) stakeholder meetings and the various practice manager forums. Where the practice had contributed to a wider review of services they had found this informative and had shared learning with staff during meetings. We reviewed practice meeting minutes and found them to be comprehensive.

Reliable safety systems and processes including safeguarding

We found the practice had a detailed safeguarding policy that addressed the needs of children and young people and vulnerable adults, and contained escalation pathways

for staff who had concerns. There was a dedicated GP lead for vulnerable adults and children who was unavailable during our inspection. Staff told us they reported any concerns if they suspected that children or vulnerable adults were at risk. Clinicians undertook enhanced safeguarding training to the appropriate level and all staff undertook safeguarding training three yearly and were next scheduled to receive update training in 2017.

The practice did not maintain a register of children on a Local Authority Child Protection Plan (CPP) or those identified as being potentially at risk (children in need). However, where concerns had been raised relating to a child or vulnerable person these were flagged on their patient record. This was achieved through safeguarding filters and alerts that had been built into the computer software system used by the surgery. GPs were able to immediately identify any concerns relating to children and to vulnerable adults. A search of the computer system and checks with partner agencies showed some children were no longer considered at risk and this had not been amended on their patient record.

During the inspection, we found that there were other reliable systems and processes in place to keep people safe. These included a chaperone policy. Patients told us that they were offered the opportunity to have a chaperone if any intimate or invasive treatment was required to be carried out by a clinician. However, not all of the staff who had completed the chaperone training had been the subject of disclosure and barring checks. This was acknowledged by the practice and they were prioritising them.

Medicines Management

We found clear, defined and appropriate arrangements were in place for obtaining medicine. We reviewed systems and processes for prescribing medicines, conducting medication reviews and monitoring of patient bloods, all were appropriate.

We found effective procedures in place to record and monitor daily fridge temperatures for the safe storage of medicines and vaccinations. Medicines were checked and appropriate and minimal stock levels maintained. However, we found patient labelled medicine had been retained inappropriately since 2012 and stored next to in date practice stock. This presented a potential risk of out of date medicines or medical supplies being used in error.

Are services safe?

We reviewed an audit from June 2013. The Clinical Commissioning Group (CCG) pharmacist had identified patients who may benefit from their medicines being reviewed to meet protocol requirements. However, when we discussed the patients with the medicines management lead in the practice, they were unaware of the pharmacist report and what actions had been taken to address issues highlighted. We found an absence of documentation demonstrating effective prescribing and monitoring of patients medicines by the practice and learning from appropriate professional and expert advice.

Cleanliness & Infection Control

All of the patients we spoke with during the inspection told us that the practice was always visibly clean and tidy. Staff told us they had sufficient access to personal protective equipment when providing treatment. We saw that the practice was visibly clean and orderly. We saw hand sanitation gel was available for staff and patients throughout the practice including in reception.

We found that there were systems in place to protect patients and staff from the risk and spread of infection. There was an infection control policy which provided staff with information regarding infection prevention and control. It included guidance about clinical waste and sharps (needles) disposal and the control and safe storage and handling of specimens. There was an appointed infection prevention control lead, the practice nurse, who was supported by a partner GP. We saw evidence of an infection control audit carried out in October 2014. We saw that there were no issues identified as a result of the audit.

However, the audit was general and failed to consider the risks of associated activities such as undertaking surgical procedures. There were also no completed cleaning schedules for either the cleaning company or nursing team to demonstrate what cleaning had been conducted and when.

We checked staff training records and saw that all staff had received infection control training. We spoke with staff about this. Staff told us that they were aware of the relevant policies and where they were located. One staff member explained the steps they took to ensure that they and patients were protected against the risks of infections. We checked staff records and found that all clinical staff had received immunisations to ensure they and patients were protected from the risks of health care associated infections.

We found that Legionella testing had been carried out. There are legal regulations in place in the UK that cover the area of legionella control and water systems, and they are enforced by the Health and Safety Executive (HSE). Any organisation with public access to their water system has a duty of care to ensure there is a risk assessment in place to ensure legionella does not become a danger to health.

Equipment

We found the practice had suitable equipment in good condition and sufficient quantities to meet the needs of patients. However, the medicines fridge was not hard wired to ensure that it could not be turned off by accident and invalidate the medicines. However, access to the plug was obstructed and the fixture was appropriately labelled asking people not to remove.

We found that medical equipment had been tested and calibrated in June 2014. All electrical equipment had also been portable appliance tested in July 2013 to ensure they were safe to use.

Staffing & Recruitment

We looked at staff files and found that clinical staff had undergone a criminal record check through the Disclosure and Barring Service (DBS) checks prior to commencing their employment. A DBS check, is performed on employees or potential employees to check for spent and unspent convictions, cautions, reprimands and final warnings. This may be used by the employer to determine the suitability of a person to undertake their role and responsibilities.

We looked at the staffing and skills mix of the practice staff. There were 18 people employed at the practice providing a good mix of clinical and non-clinical staff. Staff were available throughout their opening times to support the safe and effective treatment of patients. Locum GPs were occasionally used to cover shortages and received information and support to assist them in their role.

We found that the staffing levels were set and reviewed to keep people safe and meet their needs. We asked the practice manager how staffing levels and the staff skill mix were maintained during times of sickness or change to ensure that patient's needs could be met. The practice manager informed us that a formal process for managing

Are services safe?

holidays was in place requiring staff to obtain approval to take leave. This was designed to provide optimum staff cover at times of high demand such as during the winter months.

We looked at systems in place for the safe recruitment of staff. We looked at the recruitment records for the last two members of staff employed within the last 12 months. We found that references had been obtained for staff and criminal record checks completed prior to their appointment. This helped ensure that patients were protected from the risks of unsafe care.

Monitoring Safety & Responding to Risk

The practice had systems and processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Daily visual checks were conducted of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. However, there was an absence of documentation to support the checks having been conducted.

We found each nursing team member was responsible for their own clinical areas including cleanliness and monitoring of stock levels such as medication and dressings. However, we found there was no oversight of the nursing team to ensure sufficient systems were in place regarding the management of supplies.

A fire risk assessment had been conducted in March 2013 and was due for renewal in November 2014. Fire tests were conducted weekly and fire wardens had been appointed and fire evacuation awareness training delivered to all staff.

Arrangements to deal with emergencies and major incidents

We saw there was appropriate and sufficient emergency medical equipment and medicines available for use by trained staff, including oxygen and a defibrillator. Staff knew where the emergency first aid equipment was located and confident in providing emergency care. We reviewed staff training records and found staff had received training in cardiopulmonary resuscitation (CPR). The practice required staff to undertake this to enable them to respond to foreseeable emergencies.

We found that medical equipment had been tested and calibrated in June 2014. We found there was a defibrillator in place and oxygen was safely and securely stored with appropriate signage displayed. A defibrillator is medical equipment **used in the treatment** of life-threatening cardiac care

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. It addressed arrangement in the event of loss of the computer system and telephone system.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment was delivered in line with current legislation and recognised best practice. Individual GPs were personally responsible for adherence to National Institute of Health and Care Excellence (NICE) guidelines. The GPs also benefitted from additional support and guidance provided by the practice prescribing advisor.

We asked the practice how they assessed and monitored the quality of care received by patients. The practice explained how they provided GPs with data reports produced from the electronic patient record system to monitor and inform service delivery. However, we found no evidence of the findings being analysed and discussed to monitor provision of care.

The practice showed us and explained how they reviewed and responded to out of hours and hospital discharge information. The GPs told us they reviewed all documentation relating to patients on an individual clinical need.

Management, monitoring and improving outcomes for people

The practice had limited evidence of completed clinical audit cycles. A clinical audit cycle is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. We discussed with GPs their individual clinical audits and found that they were unable to provide evidence of completed audit cycles as they told us that they had been submitted to their appraiser and were not available for reference and learning. We spoke to another GP who had conducted an audit in relation to the Medicines and Healthcare Products Regulatory Agency (MHRA).

Effective staffing

The practice employed 18 clinical and administrative personnel. We looked at two recruitment files and found that the last two people employed had two references checked, their qualifications and registration details verified with their professional regulating body. Their identification had also been confirmed prior to commencing their employment.

We reviewed staff files for clinical and non-clinical staff. Staff had received annual appraisals and feedback on the person's performance was also sought from colleagues. Staff told us they felt supported by colleagues and were able to approach them for advice and support. Some clinical staff did not benefit from the opportunity to have individual supervision but were invited to clinical and practice meetings.

Working with colleagues and other services

We asked staff about how they ensured the timely review and management of patient blood results and recording information received from other health care providers, for example discharge letters and notifications. We found that the practice had protocols in place to ensure the timely and effective review of information. Each GP reviewed all clinical information about their own patients in accordance with their procedures. However, we found that there was a delay in routine referral letters being sent, in some cases of over a week. This was known to the practice and appropriate action was being taken to improve the situation.

We found regular multidisciplinary meetings were held bimonthly and that detailed records were maintained of discussions. Where actions had been assigned to people these were reviewed at subsequent meetings. This included reviewing all unplanned admissions or readmissions of people. The practice told us how they had spoken directly with patients who had frequented Accident and Emergency services and made subsequent referrals to the respiratory nurses to mitigate the risk of readmissions.

The practice appointed clinical leads to co-ordinate and oversee the care of patients with long term illnesses such as palliative care patients, diabetic patients and those patients requiring methadone (substance misuse). Patients prescribed methadone were closely monitored, and the clinicians worked closely with the Community Drugs Action Team. Patients were encouraged to attend regular health screenings where appropriate and participate in vaccination programmes. As part of patients' annual health review the clinicians assessed them for anxiety and depression. We found patients had been referred appropriately to specialists in an appropriate and timely way. We also found patients had been advised regarding specialist services they could access to meet their individual needs and had been signposted to additional support networks to assist them.

Are services effective?

(for example, treatment is effective)

A representative from a care home told us that they valued their relationship with The Hamilton Practice. They found both administrative and clinical staff responsive and supportive in meeting the resident's needs in a timely and professional manner. They spoke highly of the case manager who worked at the practice and acted as a conduit for information between the GPs and the district nursing team.

Information Sharing

We saw that multi-disciplinary meetings took place at the practice and were well attended by a range of other health professionals to co-ordinate care and meet the needs of the patients. Palliative care meetings took place monthly and doctors and managers from the practice met with Macmillan nurses and district nurses to ensure there was a joined up approach to care and treatment for the patient. All were well managed and documented.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record SystemOne to coordinate, document and manage patients' care. All staff were fully trained on 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

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child

(16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. We also spoke with parents of young children. They told us the clinicians confirmed their relationship with the child and whether they agreed that their child could be immunised before care was provided.

Staff demonstrated that they were aware of the Mental Capacity Act 2005 (MCA) and how it may relate to patients. The Mental Capacity Act is designed to protect people who may require support to make decisions which are in their best interest. Clinicians displayed guidance in their consultation rooms as reminders of the principles. Where a patient may not have capacity or required additional support to make a decision, they worked with the community matron and specialist teams.

We looked at the procedure in place for obtaining patient consent prior to receiving surgery. We found consent forms were completed appropriately and included explaining the benefits and potential risks of such procedure. Patients had all signed and dated their consent form agreeing to the procedure being undertaken.

Health Promotion & Prevention

We found that all new patients were invited to attend a new patient check where a brief medical history was obtained and additional health services offered. The checks were conducted by the practice nurses and patients referred to GPs where appropriate, such as to review medication.

We found a range of health information available to people within the waiting areas. This was regularly reviewed to ensure the information remained current.

There was a low uptake of the flu vaccination programme compared with the national picture but this may have been distorted due to the pharmacist being able to administer the vaccination. A meeting had been held within the practice to address the issue and to consider means of increasing attendance by patients at the vaccination clinics.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We found people who were bereaved were referred to their GP and/or letters were sent to parties inviting them to contact the practice if they required support.

Staff told us the practice had patients with physical disabilities such as those who were blind or had mobility issues and reasonable adjustments had been made to assist them. We asked what training and support staff were given to meet people's individual needs and ensure they were treated with respect and compassion. Staff told us they felt confident in supporting people who may experience difficulty communicating or present differently from others due to their lifestyle choices. Although they had not undertaken specific training, we witnessed staff being patient, polite and helpful with enquiries. We saw and people told us that staff respected and observed confidentiality.

There were facilities available so people could speak privately with staff so not to be overheard by others and these were used. There were no signs displayed within the communal areas informing patients of this service.

During a physical or intimate examination of a patient staff invited patients to have a chaperone present. A chaperone is a person who is present during an examination as a safeguard for all parties and is witness to continuing consent.

Where difficult or sensitive messages had to be conveyed staff ensured the person was given sufficient time with the GP so that they could fully explain and support them.

The practice told us they had removed a patient from their register in the past for being abusive to staff or other patients. We found they had a procedure in place to ensure that any excluded person could still access medical services.

We saw that there were private consulting and treatment rooms used for discussions with patients. Patients and staff told us that they were not interrupted during a consultation with the doctor and their dignity was respected at all times.

Female patients told us that they could see a female GP if they wished to at the practice. We saw that consulting rooms had curtains around the examination couch to maintain patients' privacy.

Care planning and involvement in decisions about care and treatment

The nurse told us that she explained treatments and tests to patients before carrying out any procedures. Patients were given an explanation of what was going to happen at each step so that they knew what to expect. Patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

We found there was a system in place to identify pregnant mothers which may have an existing health conditions or prescriptions that may require reviewing. The practice recorded such conditions on maternity booking forms and these are reviewed at antenatal appointments to inform care planning. The practice actively promoted the flu vaccination programme for pregnant mothers. The health visitors and midwives supported post natal checks conducted by the GP.

Patient/carer support to cope emotionally with care and treatment

Patients were not routinely asked if they had caring responsibilities on registering with the practice. However, if this information was disclosed, patients were invited to complete an identification and referral form so the practice could endorse the patient record accordingly and consider this when providing care and treatment.

Patients told us they felt involved in making informed decisions about their care or their family members. The staff at the practice were very good and always pleasant. Staff supported people to make decisions. Where, family, friends and advocates were involved in the care of patients this was recorded on the patient file and disclosures were made in accordance with the patient's wishes. Patients were also referred to other sources of information such as websites and community support groups to assist them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they addressed patient concerns reported to the practice, in person, in writing and on their practice website or via the NHS choices website. The practice was able to demonstrate that they had responded to the concerns of patients. For example, the practice had changed their telephone number and appointment system in response to patient concerns raised through a number of forums.

We found the practice offered a range of specialist clinics including diabetes, asthma, chronic obstructive pulmonary disease (COPD). The practice was also able to benefit from other services co-located within the building such as health visitors, physiotherapy, and speech and language therapy.

We found the practice had strong and effective communication channels established with commissioners of services, local authorities and other providers to support the provision of coordinated care and treatment for patients. For example, the practice identified that in previous years there had been a delay in patients who were house bound who received flu vaccinations. Therefore, they coordinated the administering of the vaccinations with the community district nursing teams to ensuring the timely delivery of the vaccination service to some of the most vulnerable patient groups.

The practice told that they sent letters to patients inviting them to attend flu clinics. Posters advertising the service were displayed in the communal waiting areas and information was posted on the practice website. However, they had a lower than average flu vaccination rate for patients 75 years and over and a lower than average vaccination rate for shingles. The practice told us that they were continually revisiting their approach to enhance the uptake rate.

Tackling inequity and promoting equality

Patients were offered and supported, where appropriate, to use the choose and book service, a national electronic referral service. The service gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. As a result patients had control over their referrals, rather than being seen at a hospital or clinic they would not choose.

We found that the needs and wishes of people with learning disabilities were well met. At the time of our inspection the practice had 21 people on their learning disability register and they operated a tiered review system, all reviewed by the same GP. Carers for each person were known and details entries maintained on their patient record. The lead GP had established good channels of communication with partner services and held regular discussions with the community learning disabilities nursing team. Where vulnerable people with learning disabilities had been identified, multiagency teams had worked together to ensure the timely and appropriate escalation of concerns to meet their needs. Learning from individual cases had been disseminated amongst local practices to enhance service delivery.

We found health screening for over 40 year olds and over 75 year olds was well received. Patients we spoke with appreciated receipt of a printed report so they could understand and monitor their health. The attendance of the Princess Alexandra Hospital phlebotomy service was highly valued by both practice and patients and was designed especially for patients with acute needs. The practice wrote to the parents of all children aged two, to four inviting them to attend flu vaccination clinics which were held separately to encourage attendance.

Access to the service

The practice had considered the accessibility of the service for their patients. They told us patients could make appointments on the telephone, in person, or online. Text appointment reminders were sent for those patients who had signed up for the system. The practice offered flexibility in access to the service by increasing the duration of appointments, supplementing appointments with telephone calls and home visits whilst delivering care jointly with other community health professionals.

The practice had subscribed to a local out of hours service which answered calls and saw patients as necessary. The practice closed for half a day every three months as protected time for staff training. It also closed for an hour each day when the phones were diverted and only emergency calls responded to.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person

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

who handled all complaints in the practice. However, the policy had not been implemented current practice as there was no lead GP appointed with overall responsibility. We found no complaints leaflets in reception and the appeals process documented within the leaflet was not representative of current practice.

We found there was no recording of verbal complaints or those submitted via the practice website. We found that

there had been three written complaints and these had been acknowledged and responded to by the practice manager. We found learning outcomes from complaints were not always identified, although, staff told us complaints were openly discussed at team meetings and learning was shared.

Staff encouraged patients to comment on their experience via the practice and NHS Choices website.

Are services well-led?

Good 

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

Our findings

Vision and Strategy

We saw that the practice had a patients' charter dated 16 March 2004 which set out its philosophy to provide a dedicated primary care team to achieve health services which met the patients' requirements. We spoke to staff who described the organisational culture as open, friendly, supportive and caring and responsive to staff needs.

The Hamilton Practice profile document 2014/2015 detailed some of the practices' aims and objectives, three of which they had achieved. These were to become a paper light surgery in 2008, a training and teaching practice in 2011, and a provider of minor surgical procedures. We were told by the practice manager that practice was intending to increase its consulting room capacity to meet patient demand and had submitted a planning application to NHS England.

We saw the practice had also conducted extensive work forecasting clinical need to inform the skills mix of staff. The practice had recently been successful in appointing a new partner. At the time of our inspection the practice had employed a long-term locum doctor, as they were mindful of delivering continuity of care for patients.

We saw that the practice did not operate a staff performance monitoring system outside of annual appraisals to recognise and reward good performance or to identify any potential underperformance. All the staff we spoke with said they felt supported and had training and development opportunities. There were regular practice meetings although some staff did not feel comfortable raising issues in the open meeting and would rather raise them prior to the meeting with the practice manager.

We found that the practice had arrangements in place to cover during staff holidays and periods of leave. This was in place to minimise disruption to services. However, despite leave requiring approved we found delays had occurred in routine referral letters being sent as administrative staff were covering for absent staff members.

Governance Arrangements

Each GP partner had specific areas of responsibility such as finance, nursing team, medicines and prescribing, training, and safeguarding. Although we found there was no clinical governance lead. There was also no formal register of corporate risks at the practice. However, we saw that some

risks had been identified and action taken to minimise their potential impact. For instance, there was a contingency plan to deal with loss of utility services in the building. Risks had also been considered and action taken in respect of support to staff.

We found a clear meeting structure rota was employed and known and adhered to by staff who recognised and valued the opportunity of discussing issues. All staff and partner health services were aware of which meetings and when they were required to attend and contribute to.

Leadership, openness and transparency

The practice used the Quality and Outcomes Framework (QOF) as a performance monitoring tool. This is an annual incentive programme designed to reward good practice. The practice was able to demonstrate that it considered their data and reviewed performance from October 2014 onwards to ensure they met their targets.

We found that patients were provided with information about the NHS Care Data programme. This related to the sharing of health information with other healthcare providers for improved patient outcomes. We saw that the practice had provided a clear explanation and shown that patients could make a choice about agreeing to this proposal.

GPs had been appointed lead areas of clinical responsibility such as surgery, diabetes and vulnerable adults and children. However, when we spoke to staff not all were aware of the specialist areas they had been appointed to lead on. Staff received support and guidance to ensure they were able to undertake their role safely and effectively. Administrative staff received a comprehensive induction over two weeks and clinical staff a week induction programme where they received input from all areas of the business including the administrative and clinical team and external parties such as the CCG.

Practice seeks and acts on feedback from users, public and staff

The practice operated "Friends of the Hamilton Practice" which consisted of a group of between five and six patients who had formed an interest group for the betterment of the practice. They had a notice board within reception and provided a number of services such as organising patient education sessions, attending discussions with the practice on common issues and representing the patient's voice and fundraising.

Are services well-led?

Good 

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

The practice had reviewed the national patient survey information and openly discussed it with their staff and sought ways of addressing issues. Patients we spoke with felt listened to and able to raise concerns and were confident they would be responded to. Comments recorded on the NHS choices website had also been responded to and individual concerns raised in person or in writing were addressed in a timely and appropriately manner.

The staff we spoke with described the working environment as supportive. They felt able to express their views to the practice manager and were confident that any suggestions they had for improving the service would be taken seriously.

Management lead through learning & improvement

We saw significant incidents were appropriately recorded, investigated and action plans put in place to help to prevent them occurring again. Staff were informed of all such incidents through team and clinical meetings and learning shared in a timely and open manner.

The practice was proud of their status as an approved training practice for the training of General Practice Registrars (GPR). GPR's are doctors in training who are qualified doctors and have already worked in hospitals as junior doctors for at least three years. We spoke to the GPR who spoke highly of the opportunities and support they had received from both administrative and clinical staff. They valued the open culture and the opportunities to speak with colleagues informally during the 10:00am coffee break and more formally in practice and clinical meetings and during their supervision sessions. GP partners acknowledged the benefits and valued having GPR work at the practice bringing new and innovating ways of addressing patient needs. All clinical staff had protected time for study.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
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Regulation 13 HSCA 2008 (Regulated Activities) Regulations
2010 Management of medicines

People who use services were not protected against the risks associated with the safe use and management of medicines as the practice failed to respond to prescribing information from the Clinical Commissioning Group pharmacist. Regulation 13.