Dr Dawton and Partners

Quality Report

27 Humber Road, Springfield, Chelmsford, Essex
CM1 7PE
Tel: 0844 387 8773 & 01245 204044
Website: www.humberroadsurgery.nhs.uk

Date of inspection visit: 18 February 2015
Date of publication: 08/05/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Dawton and Partners on Wednesday 18 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to succession planning.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was 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 a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

However there were areas of practice where the provider should make improvements.

- Maintain records of meetings to reflect discussions, learning and information sharing.
- Conduct an environmental risk assessment to identify risks to patients, staff and visitors to the practice.
- Conduct Legionella assessment and testing, as appropriate

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough. There were effective systems in place for lessons learnt to be communicated widely enough to support improvement. Risks to patients who used services were assessed, the systems and processes to address these risks.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was 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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice worked with local care homes to provide a responsive service to the people who lived there. They maintained a frailty register, working with partner services to coordinate patient care. We saw good examples of joint working with the district nursing team.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them. Patients also benefited from access to independent specialist advocacy services.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high for all standard childhood immunisations when compared to national averages. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, traveller communities and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the care of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice has a GP responsible for leading on mental health. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We reviewed the findings of the National Patient Survey 2014 for which there were 122 responses from the 271 questionnaires distributed to patients, a response rate of 45% of those people contacted. The practice performed above average within their Clinical Commissioning Group in relation to patients waiting 15 minutes or less for their appointment, respondents with a preferred GP usually get to see or speak to that GP and 94% of respondents who described their overall experience of this surgery as good. However, the practice performed was just below the Clinical Commissioning Group average, by 2% for respondents being able to get an appointment to see or speak to someone the last time they tried.

We provided the practice with comment cards ahead of our inspection and invited patients to complete them so we may capture their experiences of the service. We reviewed 21 completed Care Quality Commission comment cards and comments on the NHS choices website. These were positive about the care patients received. Patients told us staff were friendly, polite and helpful to them. They understood they had confidence in the clinical team and were happy to see them for assessment and treatment.

We spoke with three patients in attendance at the practice on the day of our inspection. They all told us how friendly, supportive and caring they found both the clinical and administrative team.

We spoke with partner health and social care services who reported that they experienced an excellent service from the practice. They told us they had confidence in all staff who were described as responsive to patients needs and always honoured requests for home visits where the patients were unable to attend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Maintain records of meetings to reflect discussions, learning and information sharing.
- Conduct an environmental risk assessment to identify risks to patients, staff and visitors to the practice.
- Conduct Legionella assessment and testing, as appropriate.

Dr Dawton and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP.

Background to Dr Dawton and Partners

The practice service is located in a residential area on the outskirts of Chelmsford town. It has a patient population of approximately 8,000. The practice consists of four partner GPs, one female Partner and three male GP partners, as well as a salaried female GP to take four clinical sessions a week. The practice has a practice nursing team including a healthcare assistant who conducts phlebotomy (the taking of blood). The practice is a teaching practice aligned to St Barts and The London Hospitals and also works with local schools providing shadowing experience and support for students considering a career in medicine.

The practice holds a General Medical Service contract. This is the type of contract the practice holds with NHS England to provide medical care to patients.

The practice has a comprehensive website providing a wealth of information for patients to understand and access services, including useful links to specialist support services.

The practice has opted out of providing out-of-hours services to their own patients. The services are provides by Essex Emergency Care Services. Although patient may also call NHS 111 service for advice and guidance. Information is provided to patients in their practice leaflet and patients are actively encouraged to call them prior to attending accident and emergency services.

Why we carried out this inspection

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

Comprehensive inspections are conducted 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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 February 2015. During our visit we spoke with a range of clinical and administrative staff and spoke with patients who used the service. We reviewed 21 comment cards completed by patients who used the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with, were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, when the practice received Medicines and Health Regulatory Agency alerts the practice manager shared them electronically with the full clinical team. All emails were sent with a read receipt to show they have been opened by the clinicians. The practice manager also spoke with staff individually and collectively to confirm receipt and escalate any concerns. A GP was responsible for overseeing and actioning the notifications.

We reviewed safety records, incident and accident reports for the last year of which there were two entries. The details of which were clearly recorded and action taken and recommendations made to learn from them. The accidents were discussed and documented within the practice meetings minutes. The practice had commissioned further health and safety training for the staff in response to the recorded incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice partner meeting agenda held weekly and at the practice staff monthly meetings. During the meetings they reviewed actions from past significant events and complaints. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked three significant incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. The practice also conducted a review of their incidents to identify trends and learning.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Some staff were awaiting their update training and this was scheduled to occur within the next three months. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had an appointed GP lead in safeguarding vulnerable adults and children. They had been trained to level three the required clinical level and could demonstrate they had the necessary knowledge to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice had recently introduced a new electronic patient record system and were currently read coding patients to highlight vulnerable patients on the system. This included information to make staff aware of any relevant issues when patients attended appointments. For example, where a patient may have a carer, it identified this and the person's relationship with the patient and their contact details.

There was a chaperone policy, which was visible on the doors and within the consultation and treatment rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All clinical staff had been trained as a chaperone and the GP requested a nurse or health care assistant to be present during examinations where required. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities

when acting as chaperones, including where to stand to be able to observe the examination. All staff had undertaken criminal record checks to assess their suitability in their roles and to undertake this additional sensitive duty.

The practice has a system for identifying children and young people with a high number of A&E attendances. The practice conducted an audit and identified 92% of their attendances by patients were appropriate. Where information was requested for the protection of vulnerable adults and children the GPs responded by either preparing a written report or attending case conferences and reviews.

The lead nurses responsible for providing childhood immunisations monitored children's attendance. Where children failed to attend the practice wrote to the family requesting attendance but then followed up with the health visitors or school nurse, if they failed to respond after three contact attempts.

Medicines management

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

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

We saw records of clinical audits prepared in response to their CCG pharmacist review of prescribing data.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. This was formalised within the practice repeat prescribing policy.

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

Cleanliness and infection control

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

The practice had a clinical lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

We saw evidence that the lead had carried out an audit, conducted in 2014. The practice nurses and GPs maintained individual room cleaning schedules for each treatment and consultation room, documenting when equipment and work surfaces were cleaned. Where cleaning issues were identified they were escalated to the GP partners and practice manager and we could see they had been resolved in a timely and appropriate way.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury undated and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) dated February 2015. The practice had discussed the testing but not undertaken an assessment or commissioned testing of the system in line with their policy. The practice agreed to arrange to arrange an assessment immediately.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was July 2014 and next testing date was 25 June 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. This was last conducted in March 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken for staff prior to their employment. For example, we checked three staff files for recently employed staff and found proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

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

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A lot of recent changes had been made to the building following the appointment of the new practice manager who had worked closely with the partners to drive improvements in the clinical and general practice environment. No environmental risk assessment had been conducted but visual checks were conducted every day, although were not recorded. The practice also had a health and safety policy and was considering asking for expressions of interest from staff member to be the health and safety representative.

The practice did not have a risk log, but the partners were very aware of potential threats to the ability to deliver services. Succession planning for GP retirement was acknowledged as a priority. Such risks were openly discussed at GP partner meetings and actions agreed and addressed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: when a patient presented at reception with declining health, staff immediately contacted the GP and ensured they received emergency medical intervention prior to an ambulance arriving.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan dated February 2015 was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan could be accessed remotely from the practice in the event that access to the building could not be gained. The risks identified included power failure, adverse weather,

Good

Are services safe?

unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of their internet service provider should their computer systems fail.

The practice had a fire risk assessment, dated October 2013 and included actions required to maintain fire safety such as the regular testing of the fire drill and maintenance of the equipment. Records showed that staff were up to date with fire training and that they practised regular fire drills and their fire extinguishers were tested in January 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice partners shared and discussed new guidelines. We spoke with a practice nurse who confirmed that the GP shared best practice with the wider clinical nursing team and identified where changes were required and ensured these were implemented. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, safeguarding, contraception and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We found the practice had made significant improvements to their antibiotic prescribing, having previously been identified as a high prescriber within the Clinical Commissioning Group (CCG) when comparable to similar practices. The practice addressed prescribing practices by individual GPs and they were continuing to actively monitor their performance through further audit cycles. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans.

The practice compared their referral rates with comparable practices within their CCG and Local Commissioning Group LCG. The practice did not, however, monitor delays with referrals or rejections for those patients who had be incorrectly referred for assessment or treatment.

The CCG had identified that the practice had higher referral rates for secondary dermatology and gastroenterology treatments. The practice had therefore reviewed their referrals systems and have since seen a reduction. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. Staff spoke positively about the introduction of the new electronic patient record system which they understood would assist them to obtain and analyse clinical and performance data more efficiently to inform practice.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice showed us six clinical audits that had been undertaken in the last year. All six were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice was identified as prescribing specific medicines outside of normal thresholds, they conducted an audit of prescribing non-steroidal anti inflammatory drugs (NSAID), they found that GPs had adopted prescribing preferences and therefore educated them on other alternative medicines or care strategies to employ. They found this resulted in reduced prescribing of the medication. Other examples included audits on Benodiazipine, where the practice had been identified as low prescribers. This audit's findings were consistent with the practice policy not to prescribe sedatives as they may be highly addictive.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, we found high screening rates for cervical cancer. However the practice acknowledged challenges in relation to increasing uptake rates for patient bowel screening for cancer. The practice acknowledged that improvement was required for diabetic patients to manage their conditions better. In order to achieve this, the practice appointed a clinical lead with responsibility for diabetes who was also supported by two practice nurses specialising in diabetic care. The practice considered this a priority area of work for 2015.

The practice made best use of clinical audit tools, formal clinical supervision and staff meetings to assess the performance of clinical staff. Staff had clear areas of responsibility and spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. However the practice reported poor attendance by some patients and a commitment to try and improve the attendance by this patient group. Patients who required health checks, blood tests etc. to continue the authorisation of medicines safely and failed to engage with the practice were written to advising them of the importance of the checks.

The administrative staff flagged up relevant medicines alerts when the GPs were prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed disparities within the practice performance that had been or were being actively addressed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with GPs electing to lead on a range of specialist areas.

All GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the nursing team was encouraged to apply to the partners for appropriate funding for training and education to aid them in performing their clinical responsibilities. As the practice was a teaching practice with Barts and The London Hospitals, doctors who were training to be qualified as GPs were offered extended appointments and had access to one of the partner GPs throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical screening. Those with extended roles for example in conducting diabetic examination were also able to demonstrate that they had appropriate training on the Warwick Course to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and support those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge

Good

Are services effective?

(for example, treatment is effective)

summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses, community matron and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

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. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the assessment. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). The practice told us a number of patients had chosen not to engage in the sharing of information

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, SystmOne to coordinate, document and manage patients' care. All staff were recently trained on the system although only introduced two months ago. 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

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice told us of how they supported patients be supported to make their own decisions and these were documented and shared in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented and the information scanned into the electronic patient notes with a record of the relevant risks, benefits and complications of the procedures.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant and/or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice held a register of those patients in various vulnerable groups. All 42 of their patients with learning disabilities were offered annual health checks and allocated longer consultation time. The learning disability GP lead conducted all

Good

Are services effective?

(for example, treatment is effective)

assessments and worked closely with the patient and their care team, including the specialist learning disability nursing team to coordinate care and services to meet the individual's needs.

The practice was extremely committed to educating patients on the risks of smoking. They had identified the smoking status of all their patients and only 16% of their patient population were declared as smokers. This was low when compared to neighbouring practices and national figures.

The practice's performance for cervical smear uptake was 81.2%, above their required target percentage and better than other practices within the CCG area. A named nurse was responsible for following up patients who did not attend screening. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Patient Survey 2014, and a survey of 421 patients undertaken by the practice's Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the National Patient Survey showed the practice was rated 'among the best' for patients. Patients consistently rated the service highly relating to their treatment by the clinical team. 100% of the patients had confidence and trust in the last nurse they saw or spoke to with 94% of the respondents described their overall experience of the surgery as good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and they were overwhelmingly positive about the service experience. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice operated a system to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. The practice was able to describe to us examples of action they had taken when patients had been abusive to staff. This included a review of the alleged abusive behaviour by the GP partners, and referral to more appropriate services.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the National Patient Survey showed, 94% of patients said the GP was good at listening to them, 92% said the GP was good at explaining tests and treatment with 96% of patients explaining the nurses were good at explaining tests and treatments. Of these, 85% of practice respondents said the GP was good at involving them in decisions about their care. These findings were supported in the comment cards we reviewed from patients.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The practice reported no current needs for the translation service by patients.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the

Good

Are services caring?

practice and rated it well in this area. We saw a wealth of information available to support patients and their carer's. Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The PPG patient survey found 73% of their respondents found the information displayed on the practice noticeboards and within leaflets to be very useful or fairly useful. This was supplemented with additional services such as a Carers Clinic held on the last Wednesday of every month at the surgery. This was well attended and co-ordinated by a carer who understood many of the challenges incurred by patients. The practice's computer system also alerted GPs if a patient was also a carer. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw the practice management meetings and Patient participation Group (PPG) meeting minutes where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the introduction of a named doctor for patients over 75 years or those considered vulnerable under the Department of Health rules.

The practice had an active PPG with 20 regular attendees and approximately 30 virtual members. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. They had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the PPG surveyed patients to ask about their experiences of the service initially addressing the physical layout of the premises ease of booking appointments and then the clinical service patients received. The last patient survey results for 2014 showed continued high patient satisfaction levels The PPG continued to work with the practice to reduce the number of patients who failed to attend appointments, of which there were 85 appointments missed in January 2015 amounting to an estimated 1100 minutes of clinical time lost. The PPG fully supported the practice to advertise the time lost through non-attendance of patients and welcomed the introduction of the text appointment reminder service for patients. The PPG also worked with the practice to reduce waiting times for patients calling the practice between 8:15am and 9:15am. An action plan was in place and the practice had allocated additional resources and staff to meet patient demands during peak times. All issues raised by the PPG were addressed during the PPG meeting with representation form the practice present and decisions clearly documented.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They opened Saturday mornings to accommodate their working age patient population who may have to commute and/or experienced difficulties attending week day appointments.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that elements of the equality and diversity training was included in all their training modules. Staff told us how they were mindful how they referred to patients so not to cause offence and checked with patients how they wished to be referred, as opposed to assuming.

The practice was situated on the ground floor of the building with all patient services accessible. The practice had been a residential home and been adapted, this presented challenges in the lay out of the premises and access to some consultation and treatment rooms were through a narrow corridor that may present difficulties to patients with mobility aids. However, the PPG had worked closely with the practice to address difficulties that may be experienced by patients, resulting in the introduction of sliding electric doors to aid entry. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8:15am to 12pm and 12:45pm to 6:30pm on weekdays. Evening appointments were offered one evening a week on rotation either, Tuesday, Wednesday or Thursday till 8:30pm. Saturday pre bookable appointments were available between 8am and 10:30am. Any patient, who called the practice prior to 10am where possible, would be offered an appointment that morning with the duty doctor.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointment. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

An online booking system was available and text message reminders were sent for all appointments. Longer appointments were also available for patients who needed them and those with long-term conditions or vulnerability needs. This also included appointments with a named GP or nurse. Home visits were made to the three local care homes and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Staff told us of how they try to accommodate patients even when they attend late for appointments or present with an immediate medical need.

The practice was sensitive to the needs of people experiencing poor mental health. The practice had a GP lead with experience as a section 12 Mental Health Act doctor. This experience was invaluable for understanding, responding to and accommodating the needs of people who experience poor mental health. The practice had a quiet room located away from the general waiting area that was made available to people. They offered flexibility for appointment time and duration. The practice monitored their patient suicide rates, which were low when compared to similar size practices within the CCG.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person, practice manager who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, notice and practice leaflet. Patients we spoke with were not aware of the process to follow but felt confident that if they had a concern and raised it with a member of staff it would be addressed.

We looked at six complaints received in the last 12 months and found all had been appropriately recorded, and addressed in a timely and appropriate manner apologising to the complainant where appropriate and justifying clinical decisions where necessary.

The practice partners reviewed all complaints and discussed them collectively. A partner would then formally respond with the practice manager. They had identified no trends in the complaints received. However, lessons learned from individual complaints had been shared with staff and acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a commitment to deliver high quality care and promote good outcomes for patients. We found an absence of documented detailing the practices strategy such as a five yearly plan. The practice partners discussed and acknowledged an absence of succession planning for the partner's imminent retirement within the next five year.

The practice premises had been renovated and within the design there was capacity to extend clinical facilities to the first floor. However, the practice partners had no current intention to do so.

We spoke with staff and they all knew and understood the partners commitment to their patients and intentions to provide good accessible care. Staff knew what their responsibilities were in relation to these. Although, some new staff members wished to learn more about the practice and how best they can individually and collectively contribute to improving patient outcomes. This was welcomed and encouraged by the practice team who spoke highly of their staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practices' computerised system. We looked at some of the policies and found them to be generic and not individual to the practice or how it operated. For example, we reviewed the legionella policy and procedure and found that it had not been followed by the practice. This was acknowledged by the practice who assured us they would review them to ensure they were reflective of their practice and national guidance.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that the practice may benefit from greater awareness and emphasis on QOF data through explaining the purpose to all staff and ensuring it was regularly discussed at meetings and action plans were produced to maintain or improve outcomes.

We found the clinical staff received good clinical supervision from either their peers through regular nurse meetings held monthly or through discussion with GPs as issues arose.

The practice had an on-going programme of clinical audits over the last 15 years, which it used to monitor quality and systems to identify where action should be taken. The practice held weekly governance meetings. However, these were not recorded despite the partners and practice manager telling us that performance, quality and risks were routinely discussed.

Leadership, openness and transparency

Staff told us regular partner meeting were held every Friday. However these were not minuted, there was no record kept of decisions or actions to be taken. The partners explained that they had a good, strong and respectful working relationship and were receptive to feedback from both patients, partner agencies and their peers. They took great pride in their work and their relationship with patients and staff all accepting their responsibilities and ensuring the timely completion of tasks. This was evident in the conversations we had with staff who told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues.

The practice manager was responsible for human resource policies and procedures. We saw the practice had a number of policies. For example disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the staff induction handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the National Patient Survey, PPG patient survey, comment cards and complaints received. We looked at the results of the National Patient Survey 2014, 93% of respondents said the last appointment they got was convenient, higher than

Are services well-led?

Good

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

the CCG average. The practice operated extended hours opening on a Saturday morning between 8.00am and 10.30am for pre-bookable appointments. This was appreciated by the patients we spoke with, and the GPs told us they felt it was important to provide accessible services for patients unable to attend during the normal working week.

The practice had an active Patient Participation Group (PPG) which has attracted group representation across their patient population e.g. from working patients, young parents and students. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG had carried out patient surveys and met regularly to agree the content of the patient's newsletter and priorities for the group. The practice valued the PPG, regarding them as committed and effective at listening and representing the views of their patient group. They had worked well with the practice to make improvements benefitting patients. For example, they had worked with the practice in the introduction of automatic sliding doors to aid those with mobility difficulties, bike racks had been installed and they helped maintain the practice notice boards. The notice boards displayed information on services available to patients such as the carers forum. A member of the PPG had also produced an easy read leaflet on the practice.

The practice had gathered feedback from staff through annual staff appraisals and speaking daily with staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff received regular appraisals and the newly appointed staff were reviewed constantly during their probationary period to ensure they were appropriately supported and any training needs could be addressed. Newly appointed staff told us that the practice was very supportive and their more experienced colleagues were polite, supportive and patient when assisting them.

The practice was a GP teaching practice aligned to St Barts and The London Hospitals. They had recently had students attend the practice and staff told us how they valued the opportunity to teach and learn from the students regarding new medical developments. The GPs found it challenging and enjoyable, presenting staff with an opportunity to keep their skills and knowledge current.

The practice had completed reviews of significant events and other incidents and shared with partners during their Friday meetings and with staff as they occurred to ensure the practice improved outcomes for patients.