

The Churchill Clinic

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Churchill Clinic on 9 December 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient participation group (PPG), interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all patient population groups.

Our key findings were as follows:

- Patients' said they felt safely cared for and had no concerns about their care or treatment.
- Staff were helpful, caring and considerate to patients' needs.
- Patients felt listened to and their opinions about care and treatment were acted upon.
- The environment was safe and always cleaned to a high standard.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the findings of an audit of patients with mental health illness and their access to community mental health services showed that patients were receiving a poor service. The lead GP met with the mental health community service provider and care plans for these patients were developed and access to community support for these patients has improved.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff.

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

Importantly the provider should:

- Review the privacy offered by consultation rooms to further patients confidentiality.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for safe. Staff understood their roles and responsibilities to respond to medical emergencies. Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. There were systems to help ensure staff learned from significant events/incidents. There were child and adult safeguarding policies and procedures. The practice was clean and there were systems to minimise the risk of infection to patients, staff and other visitors to the practice. The practice had effective recruitment procedures to help ensure that staff employed were of good character and had the skills, experience and qualifications required for the work to be performed. The practice had both an emergency and business continuity plan. There were service and maintenance contracts with specialist contractors, who undertook regular safety checks and maintained specialist equipment.

Good



Are services effective?

The practice is rated as good for effective. There were processes to monitor the delivery of treatment. The practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. The practice used QOF audit results for managing, monitoring and improving outcomes for patients. There were processes for managing all staffs' performance and professional development. The practice had established processes for multi-disciplinary working with other health care professionals and partner agencies.

Good



Are services caring?

The practice is rated as good for caring. Patients' needs were assessed and care as well as treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at the practice. Patients' privacy and dignity was respected as well as protected and their confidential information was managed appropriately. Patients told us they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Patients provided written and verbal consent to treatment.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice enabled patients to voice their views and opinions in relation to the quality of the services they received. Information about how to complain was made readily available to patients and other people who used the

Good



Summary of findings

practice (carers and visiting health professionals). Complaints were appropriately responded to in accordance with the practice's complaints policy. The practice reviewed and were aware of the needs of their local population and maintained links with stakeholders to plan service requirements. Patients reported good access to appointments at the practice and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

The practice is rated as good for well-led. There were clear lines of accountability and responsibility within the practice. The management team provided open, inclusive and visible leadership to the staff. There were appropriate systems to share best practice guidance, information and changes to policies and procedures with the staff. There were governance arrangements that continuously improved the practice. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided, in order to help ensure improvements were made. New staff received inductions and all staff had received regular performance reviews and appraisals. Risks to the practice and service provision had been appropriately identified and action taken to reduce or remove the risk had been undertaken.

Good



Summary of findings

What people who use the service say

We spoke with three patients and reviewed 74 comment cards completed by patients prior to our inspection. Patients we spoke with were very positive about the services they received from the practice. They were particularly complimentary about the staff and said that they were always caring, supportive and professional.

All of the comments from patients who had completed comment cards were positive about their experience of the practice, the services provided and the staff.

We looked at the NHS Choices website where patient survey results and reviews of The Churchill Clinic were available. Results showed the practice as 'Amongst the worse' for the percentage (59.6%) of patients who would recommend this practice and 'in the middle range' for scores for consultations with doctors and nurses, opening hours and patients rating their experience of making an appointment. 69.9 per cent of patients rated the overall experience of this practice as good or very good.

Areas for improvement

Action the service **SHOULD** take to improve

- The practice should review the privacy offered by consultation rooms to further patients confidentiality.

The Churchill Clinic

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice nurse specialist advisor.

Background to The Churchill Clinic

The Churchill Clinic provides medical care Tuesday, Wednesday, Thursday and Friday between 8am to 12noon and 2.30pm to 6pm, with extended hours on Monday when the medical care is provided from 8am to 12noon, 2.30pm to 8pm. The practice is closed and not accessible to patients for the two and a half hour between surgery times. The practice provides services to approximately 2,400 patients in the Chatham area of Kent.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. There are a range of patient population groups, with the majority being working aged, that use the practice and the practice holds a General Medical Service (GMS) contract with the Medway area clinical commissioning group (CCG). The practice does not provide out of hours services to its patients, these are accessed via the 111 system.

The practice has one male GP partner and one female salaried GP. There is one female practice nurse and two female health care assistants, who undertake blood tests, blood pressure tests, new patient checks and NHS health checks. The practice has a number of administration/reception staff as well as a practice manager.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

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

How we carried out this inspection

To get to the heart of patients' experiences of care 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the local Healthwatch, clinical commissioning group and NHS England to share what they knew. We carried out an announced visit on 9 December 2014. During our visit we spoke with a range of staff including both GPs, a healthcare assistant, two administration staff and the practice

manager. We spoke with three patients who used the practice and reviewed 74 comment cards where patients and members of the public shared their views and experiences of using the practice. We saw how telephone calls from patients were dealt with. We toured the premises and looked at policies and procedures. We observed how patients were supported by the reception staff in the waiting area before they were seen by the GPs. We toured the premises and looked at records of audits, meetings minutes and staff files. We also spoke with a representative from the patient participation group (PPG).

Are services safe?

Our findings

Safe Track Record

The practice had systems and procedures for risk assessments, reporting and recording incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. There were arrangements for monitoring safety, using information from audits, risk assessments and routine checks that were undertaken by staff. The staff we spoke with were able to describe their responsibilities in relation to monitoring, reporting and recording incidents and concerns. They demonstrated that they knew the reporting procedures within the practice and were aware of the external authorities that may need to be notified if appropriate. We observed examples of incidents that had been recorded by staff, including accident records and significant event reports, and we saw significant event reports recorded and summarised for the previous three years. Action plans had been created as a result where changes were required and staff confirmed that they had been involved in these actions, in order to make the necessary improvements/changes.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors. These issues were reported to either the practice manager or GPs, who created a report that was subsequently discussed by the whole staff team. Adverse events were discussed at practice meetings, in order to review all of the significant events in a formal manner. Staff we spoke with confirmed they were included and involved in these processes. Minutes from these meetings included evidence of discussions, actions taken to address issues and lessons learnt from any incident/event.

The significant events recorded for the current year and the previous two years showed there were detailed reports of incidents, the actions taken, the outcomes following any investigation and the dates of the meetings held with staff to share and discuss learning points considered.

Reliable safety systems and processes including safeguarding

The practice had systems and processes for safeguarding vulnerable adults and children who used services. One of the GPs, trained to level 3 in safeguarding, was designated to be the lead in overseeing safeguarding matters. There was a protocol and contact numbers for child and adult protection referrals available to all staff. The policy reflected the requirements of the NHS safeguarding protocol and included a 'safeguarding governance' flow-chart and the contact details of the named lead for safeguarding within the NHS England area team. Staff we spoke with told us they were aware of the protocol and the procedures to follow if they had to report any concerns.

Other health care professionals, who had contact with vulnerable children and adults, were involved in safeguarding the patients from the risk of harm and abuse as multidisciplinary safeguarding information held at the practice was appropriately being shared with the health visitor for the area.

All staff were knowledgeable and had received training in both safeguarding adults and children. Staff recruitment files demonstrated that all staff had been subject to a Disclosure and Barring Service (DBS) check (a criminal records check). Staff told us they had received training either level two or three, in safeguarding vulnerable adults and children. Records viewed confirmed this. Training records for GPs demonstrated they had the necessary training to appropriately conduct their roles in managing safeguarding issues and concerns within the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans. The GPs and practice manager told us they liaised regularly with social services to share information in relation to adult and child protection concerns that were identified within the practice. For example, a patient registered at the practice who had not registered their baby. At the time administrative staff recognised that checks and vaccinations were due to be undertaken and that there may cause for concern if these had not been carried out. The staff told us how they discussed their concerns with the lead GP and practice

Are services safe?

manager and that this had resulted in a social worker and the health visitor being contacted, in order to help ensure the baby was appropriately safeguarded, registered and receiving appropriate care and treatment.

The practice had a chaperone policy which detailed the arrangements for patients who wished to have a member of staff present during intimate clinical examinations or treatment. A chaperone is a person who serves as a witness for both patient and medical practitioner as a safeguard for both parties during a medical examination or procedure. Posters were clearly displayed for patients' information in both the waiting area and consultation rooms. The policy stated that only those staff who had received appropriate training chaperoned patients. Records showed that all staff who act as chaperones had received appropriate training and relevant disclosure and barring checks (DBS) had been carried out.

Medicines Management

We spoke with GPs and administrative staff who told us there was a system for checking that repeat prescriptions were issued according to medicine review dates and to help ensure that patients on long-term medicines were reviewed on a regular basis. Patients told us they had not experienced any difficulty in obtaining their repeat prescriptions. They told us that they were usually available sooner than the 48 hours specified and that the practice contacted them to attend appointments if a review was required.

The temperature of the medicines refrigerators was monitored and documented. The medicines refrigerator were kept locked when not in use to help ensure that refrigerated medicines were kept safely and securely. The practice had liaised with the community pharmacist, who confirmed that the refrigerator and its contents were fully compliant with the cold storage policy.

During our inspection visit the key broke in the lock of one of the medicines refrigerators. The practice responded quickly and appropriately to help ensure this issue was resolved. There was a clear contingency plan for such an event and this was initiated during our visit.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Records confirmed that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a process to help monitor the security of prescription pads for use in the printers so that the practice could track when they were used and this was in line with national guidance.

Emergency medicines were available in the practice. Staff told us these were checked regularly and records confirmed this. All emergency medicines that we looked at were within their expiry date.

There were no controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) stored at the practice.

We were told by staff that the GP's take medicines for example, pain relief, anti-sickness injections, from the cupboard and controlled drugs were obtained from the pharmacy, if required, in order to supply their home visit bags. Staff told us these medicines were checked regularly and records confirmed this.

Cleanliness & Infection Control

All the areas of the practice were clean and tidy. Patients told us they always found the practice was cleaned to a high standard, tidy and said they had no concerns about the cleanliness of the premises.

Liquid hand wash and disposable towels had been provided in the public and staff toilets. There was a notice displayed in public areas that informed patients about the importance of hand washing to help reduce the spread of infection.

Clinical rooms had clinical waste bins, along with liquid soap and disposable paper towels. Disposable privacy curtains were used in clinical rooms and there was a schedule for routinely changing them.

Sharps bins had been dated and information about safe disposal of clinical waste and sharps was displayed. In the consulting rooms there were disposable couch coverings that were changed between each patient. There was personal protective equipment (PPE) available in the clinical rooms. Records showed that the practice had a contract for the safe disposal of clinical waste. This helped ensure the risk of infection was minimised.

The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, hand hygiene, a spillage protocol, management of sharps injuries and clinical and hazardous waste management. The policy identified a member of

Are services safe?

staff as the infection control lead for the practice. Staff demonstrated a clear understanding of their role and responsibilities in relation to infection prevention and control, including referring outbreaks of infectious diseases to external agencies.

Staff told us they had received training in infection control and records confirmed this. All staff were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control.

Cleaning schedules were used and completed by staff to identify and monitor the cleaning activities undertaken on a daily, weekly and monthly basis. The practice carried out infection control audit cycles that followed up to date best practice guidance. The practice carried out analysis of these audit results, made action plans to address any issues identified and planned to repeat the audit to assess the impact of any actions taken and complete a cycle of clinical audit. Records showed that results of findings of such audits were shared with relevant staff.

The premises were maintained and there were service contracts with specialist contractors. For example, fire safety equipment testing and electrical testing had been undertaken. Clinical hand-wash basins in the practice conformed to Department of Health standards.

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

Equipment

There were processes and systems to keep the premises and building safe for patients, staff and visitors. Records showed there were service and maintenance contracts with specialist contractors, who undertook regular safety checks and maintained specialist equipment.

Equipment and the premises were appropriately checked to ensure they promoted staff, patient and visitors safety. Records demonstrated that training had been provided to staff in respect of fire safety awareness. The premises had an up-to-date fire risk assessment and regular fire safety checks were recorded.

There was a planned maintenance plan in use by the practice which took into account accessing equipment in

the event of equipment becoming faulty. Records showed that any necessary repairs reported were addressed quickly. Records also demonstrated that portable appliance testing (PAT) of electrical appliances was up to date.

Staffing & Recruitment

There was a recruitment policy that reflected the recruitment and selection processes completed by the practice. Records showed that appropriate pre-employment checks had been carried out for all staff employed at The Churchill Clinic.

All staff had a completed Disclosure and Barring Service (DBS) check (a criminal records check). The practice had a system that routinely checked with the General Medical Council (GMC) and to the Nursing & Midwifery Council (NMC) to help ensure staff maintained their professional registration.

Staff told us the practice had strategies for the staff team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system for all the different staffing groups to help ensure that enough staff were on duty. There was also an arrangement for members of staff, including nursing and administrative staff, to cover each other's annual leave. Additionally, there was a system for the practice to arrange staff cover from one of its other practices in Maidstone and Allington. Staff told us that this system worked well and helped ensure that patients' needs were met and not compromised in anyway.

There were sufficient staff at the practice, patients did not have any difficulties accessing a GP or nurse appointment and received appointment times appropriately. Patients told us they never had to wait for long periods of time to see the GP of their choice.

Monitoring Safety & Responding to Risk

Clinical meetings were held fortnightly. Minutes of these meetings detailed how decisions were made about home visits and how the practice provided sufficient hours provided for patient appointments, including emergency appointments.

Are services safe?

We spoke with all staff who were knowledgeable about prioritising appointments and worked with the GPs to help ensure patients were seen according to the urgency of their health care needs.

Safety alerts from outside agencies were received by either the principal GP or the practice manager. Safety alerts provide information to keep the practice up to date with failures in equipment, processes, procedures and substances used in general practice. Any information received in relation to safety alerts was cascaded either electronically or during practice meetings, to the GPs and practice staff. Audits related to safety alerts demonstrated they provided a clear audit trail of actions taken by the GPs to help ensure patients' safety. National data collected from incidents/events and alerts was monitored, assessed and used to improve patient safety within the practice.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. As there was a high prevalence within this practice's patient population list of mental health illness as well as alcohol misuse, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

The practice had a health and safety policy. Information was prominently displayed at the practice and included the details of the staff member responsible for health and safety. Risk assessments had been completed for the premises and these had been reviewed and updated to reflect any changes in identified risks within the practice.

Arrangements to deal with emergencies and major incidents

The practice had systems and procedures for responding to medical emergencies. Staff we spoke with, and training records confirmed, that all staff had received training in basic life support and emergency resuscitation. Staff told us they were aware of the emergency procedures to follow.

We spoke with staff who told us about the procedure they would follow to alert other staff when they had an emergency situation in their consultation/treatment rooms. They said they telephoned reception and this helped to enable staff to summon assistance and provide additional support if needed.

The practice had medical oxygen and an automated external defibrillator (AED), which was used to attempt to restart a person's heart in an emergency. Records confirmed that staff were trained in how to use these. There were systems to routinely check and record that these were fit for purpose. For example, the daily check of the oxygen cylinder on the day of our inspection had shown that the oxygen cylinder was empty. A new cylinder of medical oxygen had been ordered and was delivered during our visit. This had been recorded as a significant event. The practice had plans to investigate and learn from this event, sharing findings with staff.

The practice had an emergency and business continuity plan. The plan included details of how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services. For example, when extreme weather caused staff shortages and any interruptions to the facilities available. The arrangements for patients to continue to receive care during periods of the practice being closed due to such events, were such that appointments at one of the other practices within the group were offered. The practice also had an agreement with other local practices to use their facilities, if patients were unable to attend another practice within the group.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used national guidance and professional guidelines to promote best practice in the care it provided. Patients received care according to national guidelines. Relevant guidelines and national strategies were discussed between the GPs and made available to staff.

Patients were offered care and treatment in accordance with nationally recognised standards. There were records demonstrating that medicine audits had been carried out following the receipt of national guidelines and standards provided to the practice by NHS commissioners and other stakeholders. For example, we saw that a change had been made to the prescribing regime for the safe prescribing of licenced forms of one medicine used for promoting sleep. The audit results showed that a search of patients prescribed this medicine was completed and a list of patients, almost all children, was created. The audit results were discussed at the clinical meeting under the prescribing agenda heading. Parents of children were informed prior to switching medicine and in one case the opinion of a paediatric consultant was sought. Patients who had sip feeds, the standard was set that all patients had a malnutrition universal screening tool (MUST) – a five step tool used for identifying patients who were at risk of malnutrition) undertaken. These patients were then called in to have a MUST assessment. Patients identified as requiring input from a dietician were then referred for this service. The practice recognised that there were learning outcomes from this audit and had subsequently devised a system to assess patients within this criteria, enhanced their referrals to the dietician and the use of MUST.

We spoke with clinical staff who told us that patients' needs and potential risks were assessed at initial consultations with the clinicians. Individual clinical and treatment plans were agreed and recorded on the computerised system.

Comprehensive and detailed patient records were kept on the electronic system and that patients who had been assessed as 'at risk', for example, older patients, had care plans that were reviewed with the patient and their carer routinely. Every patient over 75 years of age had a named GP who was responsible for overseeing their care and treatment.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers who were referred and seen within two weeks. Minutes from meetings demonstrated that regular reviews of elective and urgent referrals were made, and improvements to practice were shared with all clinical staff.

Management, monitoring and improving outcomes for people

The practice kept registers that identified patients with specific conditions/diagnosis. For example, patients with dementia, learning disabilities, heart disease, diabetes and mental health conditions. The electronic records system contained indicators to alert clinical staff to specific patient needs and any follow-up actions required. For example, medicine and treatment reviews.

The practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. QOF audits were used to inform clinical meetings where information from audits were shared and discussed amongst relevant staff. Actions were agreed with regards to changes to specific treatments and therapies, if required, in order to improve outcomes for patients.

There were systems to ensure patients received care and treatment that was appropriate to their condition based on findings of clinical audit cycles. For example, following the findings of an audit of patients with mental health illness and their access to community mental health services, the practice found that patients were receiving a poor service. The lead GP met with the mental health community service provider and care plans for these patients were developed and access to community support for these patients has improved.

Effective staffing

There were processes for managing staff performance and professional development. Staff knew who was responsible for managing and mentoring them. Records confirmed that all staff had completed basic life support (BLS), information governance, infection control, confidentiality as well as safeguarding children and adult training. The nurse and health care assistants had also completed specialist training in diabetes, asthma, family planning, travel vaccines, epilepsy, coronary heart disease, chronic obstructive pulmonary

Are services effective?

(for example, treatment is effective)

disease (a long-term respiratory disease) and updates in childhood immunisations. Clinical staff said they attended external meetings and events to help further enhance their continuing professional development.

All staff said they received annual appraisals and formal supervision. All the staff we spoke with felt they received the support they required to enable them to perform their roles effectively. There was a process for GP appraisal and revalidation and there was a schedule of dates for annual appraisal and completion of revalidation for each GP within the practice. An induction programme had been undertaken by members of staff who had recently joined the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge 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 this system worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

Minutes of meetings showed that the practice had well established processes for multi-disciplinary working with other health care professionals and partner agencies. These processes ensured that links with the palliative care team and district nurses for example, remained effective and promoted patients' care, welfare and safety. Multi-disciplinary meetings were held routinely and included clinicians from the practice and all members of the multi-disciplinary team who were involved in patients' care and treatments.

GPs and health care assistant attended quarterly meetings with the palliative care team to promote a united approach to patient care and treatments. Where family difficulties were identified, referrals were made to the health visitor, who provided specialist support for mothers, babies, children and young people.

All staff told us that the practice held regular staff meetings to help ensure they were up-to-date with appropriate and relevant information. For example, outcomes of clinical meetings, significant events and governance meetings. However, not all practice meetings were recorded although regular discussions were held with staff within the practice.

There were systems to process urgent referrals to other care and treatment services and to ensure that test results were reviewed in a timely manner following receipt by the practice. Staff described the system they used to check test results and clinical information on a daily basis and how the information was shared promptly with clinical staff as a priority.

Information Sharing

The practice had protocols for sharing information about patients with other service providers. Staff were knowledgeable about the protocols and patient information was shared with other service providers appropriately. For example, there was a system to monitor patients who accessed community mental health services that also helped to ensure their care plans were up to date.

The practice used 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.

GPs told us they discussed with individual patients and carers, which consultant to refer them to based on the patients' needs and individual preferences. GPs said they only occasionally used the 'choose and book' (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) method for referrals. They told us they tended to refer patients locally, as this was what most patients preferred. Referrals to one of the London hospitals were made if requested by the patient or their carer.

The practice had systems to provide staff with information about patients that they needed. There was an electronic patient record system used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, for example, those from hospital, to be saved in the patients' record for future reference and in planning on-going care and treatment.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The practice had procedures for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments. For example, hormone implants. There was space on the form to indicate where a patient's carer or parent/guardian had signed on the patients behalf.

Staff told us how patients who lacked capacity to make decisions and give consent to treatment were managed. They said mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support.

Staff told us that if they felt the patient lacked capacity to consent to treatment, they would not carry out the treatment and would request that the patient was reviewed by the GP. GPs described the process for gaining consent from patients who were under 16 years of age and stated that they followed relevant guidance, demonstrating an understanding of the 'Gillick' competencies. (Guidance which helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). The practice displayed information in relation to an advocacy service in the patient waiting area, with contact details for patients and/or their carers who required independent support. There were procedures that helped ensure patients who lacked capacity were appropriately assessed and referred where applicable.

Staff were aware of the Mental Capacity Act 2005, and some elements of the legislation were included in the safeguarding training that staff received. We spoke with clinical staff who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment.

Health Promotion & Prevention

Staff told us about the processes for informing patients that needed to come back to the practice for further care or treatment. For example, the computer system was set up to alert staff when patients needed to be called in for routine

health checks or screening programmes. Patients we spoke with and those who completed comment cards told us they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

There was a range of information leaflets and posters in the waiting room for patients about the practice and promoting good health. Information on how patients could access other healthcare services was also displayed.

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

All new patients who registered with the practice were offered a consultation with the nurse to assess their health care needs and identify any concerns or risk factors that were then referred to the GPs.

The practice offered a full range of immunisations for children and travel vaccines. The practices' performance for childhood immunisations last year was in line with the average for the area clinical commissioning group (CCG) and there were systems to follow-up non-attenders.

The practice had systems to identify patients who required additional support and were pro-active in offering additional help. For example, vaccination clinics were promoted and held at the practice, including influenza vaccination for older people. QOF data showed that above the average number of patients over 65 years of age had received a seasonal influenza vaccination. The practice also kept a register of patients with learning disabilities and dementia which it used to help promote and encourage annual health checks for these patients.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with and those who completed comment cards told us they felt the staff at the practice were extremely polite and helpful. Comments from patients were positive in relation to staff as well as the care and treatment that they received.

Three patients told us that staff always considered their privacy and dignity. The clinical staff we spoke with demonstrated how they ensured patients privacy and dignity both during consultations and treatments. For example, curtains were used in treatment areas to provide privacy and doors to treatment/consultation rooms were closed during patient consultations and treatments.

There were systems to help ensure patients' privacy and dignity were protected at all times. The practice had a confidentiality policy which detailed how staff should protect patients' confidentiality. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality. If patients wished to speak to reception staff in confidence, a private room was available for them to use. Although the reception area was open plan the reception telephones were placed in a way that conversations on the telephone could not be heard by patients waiting for an appointment. We spoke with patients and were told that they felt their consultations were always conducted appropriately.

Consultations rooms did not have effective sound proofing in place. Staff confirmed that since having the carpet removed and replaced with professional clinical flooring that was impervious and easy to clean, the sound proofing of these rooms had decreased. The practice had spoken with the local clinical commissioning group (CCG) to determine how this issue could be addressed. A meeting was planned to discuss the issue in the near future. Patient survey results and patients we spoke with made no reference to this alteration in privacy.

The practice had a chaperone policy that set out the arrangements for patients who wished to have a member of staff present during intimate clinical examinations or treatment. (A chaperone is a person who serves as a witness for both the patient and the medical practitioner as a safeguard for both parties during a medical examination or procedure). Records showed that staff had received

up-to-date chaperone training and had had a DBS carried out. There were notices displayed in the practice informing patients that they could ask for a chaperone to be present during their consultation if they wished to have one.

We reviewed the most recent data from the national patient survey and saw that the practice was rated as the national average for patient satisfaction. For example, respondents said they could not be overheard by other patients at the reception desk and that GPs and nurses were good or very good at treating them with care and concern. The practice also received very positive feedback, with few if any negative comments, from patients during their own patient survey and from the results of the ongoing NHS friends and family test (The NHS friends and family test (FFT) is an opportunity for patients to give feedback on services that provide care and treatment. It was introduced in GP practices on 1 December 2014).

Patients with children who completed comments cards told us the practice staff treated their children with the same respect as they would when speaking with adults. They commented that the staff spoke with their child in a respectful manner and ensured they understood the care and treatment they were offered. Parents told us that staff always checked with them to make sure they had understood as well, and were agreeable to the treatment for their child.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and comment cards we received indicated they felt listened to and involved in the decision making process in relation to their care and treatment. GPs and nursing staff took the time to listen to them, and explained all treatment options available to them. They said they felt able to ask questions if they had any. Patients were able to see the doctor of their choice and 94% of patients surveyed by the practice reported that seeing a specific GP was important to them. Patients were involved in decision making and had the time and information to make informed decisions.

The practice had individual care plans for patients with a long term conditions, such as dementia and cardiac conditions. Records showed there was a care plan for such patients and that these had been agreed between the patient and their family / carer. The practice maintained a

Are services caring?

register of all patients who had a care plan. The register included details of ongoing care and treatment as well as changes made to the plan as a result of a change in the patient's condition or medication having been amended.

Staff told us that translation services were available for patients who did not have English as a first language. There were notices in the reception areas informing patients this service was available. The practice has a number of staff who were multi-lingual and staff told us they were able to communicate well with these patients registered at the practice.

Patient / carer support to cope emotionally with care and treatment

Staff were supportive in their manner and approach towards patients. Patients told us they were given the time they needed to discuss their treatment as well as the options available to them and they felt listened to by the GPs and other staff within the practice.

Patient information leaflets, posters and notices were displayed that provided contact details for specialist groups that offered emotional and confidential support to patients and carers. For example, counselling services and a bereavement support group.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting peoples' needs

Staff told us patients' needs and potential risks were assessed during initial consultations. They said individual clinical and treatment plans were agreed and recorded on the computerised system. Individual clinical and treatment plans were discussed during meetings held between clinical staff and other health care professionals involved in patients' care and treatment. This helped to ensure that patients received care and treatment from health care professional that were aware of their individual clinical and care plans.

GPs described how they discussed with individual patients and carers, which consultant to refer them to based on the patient's needs and individual preferences. GPs told us they tended to refer patients locally, as this was what most patients preferred. However, referrals to one of the London hospitals were made if it was appropriate and/or requested by the patient or their carer.

The practice had well established links with the local area commissioners. Meetings took place on a regular basis to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future.

The practice had a patient participation group (PPG). Terms of reference and the purpose of the group had been established and implemented. A survey had been developed to distribute to patients and there was analysis of the results of previous surveys which were completed by patients. PPG representatives told us they had looked at ways of recruiting new members from all of the patient populations groups and these had been successful. The practice had a website containing a section dedicated to the PPG, where recent surveys and the group's annual report could be accessed by patients and members of the public.

Staff told us there were a wide range of services and clinics available to support and meet the needs of the varied patient groups. They said they referred patients to community specialists or clinics, if appropriate. For example, referring older patients, or their carers, to groups who specialised in supporting patients and carers with

chronic illnesses. Additionally, mothers with babies or young children were referred to the health visitor. The practice had a contract with another provider to deliver out of hours care.

The practice worked closely with community nursing teams and the integrated care team to support patients with long-term conditions and those with complex needs who received care and treatment from a range of services. Patients told us they were referred promptly to other services for treatment and test results were available quickly. Staff told us that the needs of different patients were always considered in planning how services would be provided. For example, arranging home visits for housebound patients.

Tackling inequity and promoting equality

The practice premises were accessible for patients with disabilities and appropriate parking spaces close to the entrance door were provided. There was a toilet available for people with disabilities. The reception desk was not at a low level to accommodate patients using wheelchairs. In order to address this staff said they came out of the reception area, spoke with patients in wheelchairs face to face and offered a private room to have discussions in. Interpretation services were available by arrangement for patients who did not speak English.

Access to the service

Patients were able to book an appointment by telephone, online or in person. Appointments were available Tuesday, Wednesday, Thursday and Friday between 8am to 12noon and 2.30pm to 6pm, with extended hours on Monday when the medical care was provided from 8am to 12noon, 2.30pm to 8pm. Patients we spoke with and those who had completed comment cards, told us the telephone appointment booking system (for contacting the practice for an appointment on the same day) worked very well. The practice also offered pre-bookable appointments in advance. The recent patient survey conducted by the practice showed that 80% of patients surveyed were aware that they could book an appointment in advance. Staff said the extended opening hours were particularly useful for patients who commuted to work.

Patients told us they did not experience problems when they required urgent or medical emergency appointments. They told us that once they made contact with the practice, staff dealt with these issues promptly and knew how to prioritise appointments for them. The reception staff we

Are services responsive to people's needs?

(for example, to feedback?)

spoke with had a clear understanding of the triage system. This was a system used to prioritise how urgently patients required treatment, or whether the GP would be able to support patients in other ways, such as a telephone consultation or home visit. Patients found that access to urgent or emergency appointments met their needs and expectations.

The practice had recognised that whilst pre-bookable appointments were available, patients were opting for on the day appointments, which reduced access to patients that needed to be seen urgently on the day. As a result the practice had introduced a trial triage system. They had also raised patients' awareness of alternative services and had trained staff to recognise when patients might need to be seen on the day and when a future dated appointment might be more appropriate. Of the 74 comment cards we received, three cards contained comments about the triage system improving access to appointments, whilst the remainder of the cards contained comments that accessing appointments was either good or exceptional.

There was a system for patients to obtain repeat prescriptions. Patients told us they had not experienced any difficulty in getting their repeat prescriptions. Staff said the practice aimed to have repeat prescriptions ready within 48 hours of them being given in by the patient so that they received their prescriptions in a timely manner.

There were arrangements to ensure patients could access urgent or emergency treatment when the practice was closed. Information about the out of hours service was clearly displayed in the waiting room, was included within

the patient information booklet and there was a telephone message which informed patients what to do if they telephoned the practice when it was closed. Patients told us they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns & complaints

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

Practice meeting minutes included discussions of complaints received. Patients we spoke with told us they had never had cause to complain but knew there was information in the waiting room about how and who to complain to, should they need to. The complaints procedure was included in the practice information booklet for patients

There were records relating to complaints which had been made to the practice. The complaints were investigated and the outcome of each investigation was sent to the respective complainant. Letters sent to complainants included the contact details of the ombudsman. This gave patients the option of taking their complaint further if they were not happy with the way in which the practice responded. The practice also kept a log of all informal complaints. Particular issues that required change were shared at the practice meetings to help ensure that all staff learnt from the complaints that had been made.

Are services well-led?

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

Our findings

Vision and Strategy

Staff told us the practice was working towards continuing the practices' team approach in providing good quality care and treatment for patients. The practice had a written 'vision' statement or a business plan to inform individual or team objectives and it was clear from staff we spoke with that the management team promoted an inclusive approach to achieve its purpose of providing good quality care to all patients.

Governance Arrangements

There were governance arrangements at the practice and these included the delegation of responsibilities to named GPs. For example, a lead GP for safeguarding. The lead roles provided structure for staff in knowing who to approach for support and clinical guidance when required. Staff we spoke with were clear about their roles and responsibilities within the practice.

Significant events were openly discussed at team meetings and team meetings were used as a platform to learn from incidents and errors.

Management meetings were held on a regular basis to consider quality, safety and performance within the practice. This included monitoring of complaints, analysis and review of significant events. Information from the practice Quality and Outcomes Framework (QOF) was also monitored, which enabled the practice to make comparisons to national performance and locally agreed targets.

Information from clinical audits had been reviewed and actions had been taken to achieve improved outcomes for patients as well as to monitor the quality of the services provided.

The practice had completed risk assessments in relation to the premises, such as fire risk assessments, health and safety and security of the building (external and internal). Risk assessments were current and had been reviewed and updated on either a yearly basis or sooner if changes were required.

Leadership, openness and transparency

There was an open and transparent approach in managing the practice and leading the staff team. The GPs promoted shared responsibility in the working arrangements and commitment to the practice.

During a presentation given by the lead GP we were told that the practice had dynamic leadership and that they were an early adopter practice, meaning that new or updated guidance/recommendations were acted upon and implemented quickly. They told us the practice team worked very well together because of the non-hierarchical structure. All of the staff we spoke with confirmed that the practice team worked as one. The practice had good working relationships with neighbouring practices and often provided them with support and representation, which was well received.

The practice manager was responsible for human resource policies and procedures. We reviewed of the practices policies. For example, the disciplinary procedures, induction policy, as well as equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. They said they felt there was an 'open door' culture and that the GPs and practice manager were approachable. They told us they felt appropriately supported and were able to approach senior staff about any concerns they had. Staff told us that whilst there was strong leadership, the atmosphere at the practice was relaxed, open and inclusive. Staff told us they were very happy working at the practice and felt listened to and valued.

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

Staff told us they were encouraged to voice their ideas and opinions about how the practice operated and services were provided. All staff said they felt their views and opinions were valued and that there was exceptional communication and team work within the practice. All staff told us they felt part of the team and there was no sense of hierarchy at the practice. Staff told us they attended and participated in regular staff meetings and these included discussions about changes to procedures, clinical practice, and staff cover arrangements.

The practice had a whistleblowing policy and staff told us they were aware of the procedure to follow if they wished to raise concerns outside of the practice.

Are services well-led?

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

Patient engagement was managed by the practice manager, through the patient participation group (PPG) and through comments and complaints raised with the practice. The PPG representatives that we spoke with during our visit told us the management team were open and responsive to suggestions. They also told us the practice supported regular patient surveys to consider ways to improve the services provided. There was a detailed action plan generated by the practice in response to the findings of the patient survey in 2014. This gave examples of where changes were required such as accessing appointments and the implementation of the triage system. Patients we spoke with and those who completed comment cards told us they were happy to speak with staff at the practice if they needed to, in relation to positive or negative feedback about the practice or services received.

Management lead through learning & improvement

The practice learnt from significant events, incidents and training and used learning to make improvements to services provided to patients. Staff told us training updates provided them with information on current best practice or how improvements could be made at the practice. They told us training was discussed openly at team meetings and team meetings were used to learn from training attended by staff as well as feedback from complaints and incidents. Records showed that GPs and nursing staff were supported to access ongoing learning to improve their skills and competencies. For example, attending specialist

training for diabetes, childhood immunisation and asthma, as well as opportunities to attend external forums and events to help ensure their continued professional development.

Patient referrals were discussed confidentially at clinical team meetings where areas of learning were discussed, considered and shared between clinicians.

There were meetings held between the GPs and the practice manager to discuss and recognise future demands that may be placed on the practice. For example, using information and intelligence to plan for the needs of an increasing older patient population and those with long-term conditions, and the prevalence of certain conditions such as heart disease and dementia. Increased needs for service provision had been considered and planned for.

Staff files and training records demonstrated that administrative and clerical staff were also supported to improve their skills and knowledge. For example, attending specific courses in relation to coding letters according to patients' conditions and information governance. Formal appraisals were undertaken for all staff, to monitor and review performance, personal objectives and to identify any future training requirements.

There was a system to help ensure that GPs received an annual appraisal and records showed that the GP revalidation process had been implemented at the practice.