Thorndike Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Thorndike Surgery on the 2 December 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, 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.
- Patients said they were treated with 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.
- 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.

Summary of findings

However, there were also areas of practice where the provider should make improvements:

- Staff meetings that include attendance of the whole staff team.
- Ensure that clinical audits are complete audit cycles.
- Improve processes for making appointments and reducing waiting times.

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 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 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 ensure that staff employed were of good character, 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.

Are services effective?

Good

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 staffs' performance and professional development. The practice had established processes for multi-disciplinary working with other health care professionals and partner agencies.

Are services caring?

Good

The practice is rated as good for caring. Patients' needs were assessed and care and treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at the service. Patients' privacy and dignity was respected and 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. There were appropriate procedures for patients to provide written and verbal consent to treatment.

Are services responsive to people's needs?

Good

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 readily available to patients and other people who used the practice

Summary of findings

(carers, visiting health professionals). Complaints were 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. The practice had good facilities and was well equipped to treat patients and meet their needs. Urgent on the same day and pre bookable appointments were available.

Patients reported experiencing difficulties in accessing appointments at the practice and long waiting times. The practice was taking appropriate action to address these issues.

Are services well-led?

Good

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 staff. There were governance arrangements to continuously improve services. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided, to help ensure improvements were made. New staff received induction training 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.

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

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. There were appropriate and effective treatments, along with ongoing support such as medical reviews, referrals when necessary and review clinics, for those patients diagnosed with dementia, diabetes and other illnesses.

Patients were referred to other health care professionals as required. This enabled patients to have care and support with their ongoing and more complex health needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Emergency processes were in place and referrals made for patients in this population group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For those patients with the most complex needs, the GPs worked with relevant health and care professionals to lead and 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 to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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 which reflected the needs for this population 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 and those with learning disabilities. The practice carried out annual health checks and offered longer appointments if required, for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice sign-posted vulnerable patients to various support groups. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns as well as how to contact relevant agencies in 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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had advanced care planning for patients with mental health conditions, including dementia.

The practice sign-posted patients experiencing poor mental health to various support groups and charitable organisations including MIND/Medway Hope Project. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 32 patients and reviewed 35 comment cards completed by patients prior to our inspection. Patients we spoke with were generally very positive about the services they received from the practice. Many felt that the GPs and clinical staff were experienced and listened to them. There were many positive comments from patients who had completed comment cards. However, 30 of the 32 patients we spoke with and 16 of the comments cards received, raised concerns about accessing appointments and long waiting times at the practice. They considered their dignity and privacy had been respected and that staff were polite, friendly and caring. They told us they felt listened to and supported by staff, had sufficient time during consultations and felt safe. They said the practice was clean as well as tidy. Patients we spoke with reported they were aware of how they could access out of hours care when they required it as well as the practice's telephone consultation service.

We looked at the NHS Choices website where patient survey results and reviews of Thorndike Surgery were available. Results showed the practice as 'in the middle range' (these are scores that are in the middle 50% of scores nationally) for the percentage of patients who would recommend this practice, for scores for consultations with doctors and nurses, opening hours and patients rating their experience of making an appointment. 66 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

- Staff meetings that include attendance of the whole staff team.
- Ensure that clinical audits are complete audit cycles.
- Improve processes for making appointments and reducing waiting times.

Thorndike Surgery

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, a practice nurse specialist advisor and an Expert by Experience.

Background to Thorndike Surgery

Thorndike Surgery (Also known as The Dame Sybil Thorndike Health Care Centre) provides medical care Monday, Tuesday, Wednesday and Friday 8.30am to 12.30pm and 1.30pm to 6.30pm, Thursday 8.30am to 12pm and 1pm to 6.30pm. Extended surgery hours are available on Wednesday evenings after 6.30pm and on Saturdays 9am to 11.30am. The practice is closed and accessible to patients for the hour between surgery times. The practice provides services to approximately 15,000 patients in Rochester, Kent and the surrounding areas.

Routine health care and clinical services are offered at the practice, led and provided by the nursing team. There are a range of patient population groups, with the majority being older people and people with long term conditions, that use the practice and the practice holds a General Medical Services (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. Patients are informed of this via the practices patient information leaflet, website, answerphone message and signs that are posted in the waiting room.

The practice has five partner GPs and four salaried GPs. The GP's are supported by Registrars who are provided with GP training and mentorship by the partner GPs. There are four practice nurses and four health care assistants, who undertake blood tests, blood pressure tests, ECGs, new patient checks and NHS health checks. The practice has a number of administration/reception and secretarial staff as well as a practice manager. The practice has employed the services of a management consultant in order to support the practice to develop and implement its business plan, as well assistance with recruitment of GP's and additional services planned for the future.

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?

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 2 December 2014. During our visit we spoke with a range of staff including four GPs, the clinical nurse manager, three practice nurses, four administration staff, the office manager, the management consultant and the vice chair of the patient participation group (PPG). We spoke with 32 patients who used Thorndike Surgery and reviewed 35 comment cards where patients and members of the public shared their views and experiences of using the practice. We observed how telephone calls from patients were dealt with. We toured the premises and looked at policy and procedural documentation. We observed how patients were supported by the reception staff in the waiting area before they were seen by the GPs.

Are services safe?

Our findings

Safe Track Record

The practice had systems and procedures for risk assessments as well as reporting and recording incidents. There were arrangements for monitoring safety, using information from audits, risk assessments and routine checks that were undertaken by staff. There was a systematic risk log to monitor actions from risk assessments. The staff we spoke with were able to describe their responsibilities in relation to monitoring, reporting and recording incidents and concerns. They told us they knew the reporting procedures within the practice and were aware of the external authorities that may need to be notified if appropriate. We saw 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.

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. We saw that these issues were reported to either of the partner GPs or the clinical nurse manager who created a report that was subsequently discussed by the staff team. We were told by GPs that adverse events were discussed at practice meetings where significant events were reviewed formally. Minutes of these meetings included evidence of discussions, actions taken to address issues and lessons learnt from any incident/event. The practice also maintained a computerised resource database which was used as an aide memoire for staff to refer to.

We looked at the significant events recorded for the current year and the previous two years and saw that there were detailed reports of the incidents, the actions taken, the outcome following any investigation and the date of the meetings held with staff to share and discuss learning points.

Reliable safety systems and processes including safeguarding

The practice had effective systems and processes for safeguarding vulnerable adults and children who used services. One of the GPs 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 clinical staff had been subject to a Disclosure and Barring Service (DBS) check. Staff told us told us they had received training in safeguarding vulnerable adults and children to levels two or three and we saw records that confirmed this. Training records for GPs demonstrated they had the necessary level three training, in order to manage 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 clinical nurse manager told us that they liaised regularly with social services to share information in relation to adult and child protection concerns that were identified within the practice.

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 a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. Posters informing patients about the availability of chaperones were clearly displayed in both the waiting area and consultation rooms. The policy stated that only those staff who had received appropriate training would be able to chaperone patients.

We saw confirmation that refresher training in chaperoning was provided and attended by staff. The practices' policy for DBS checks on staff stated that all clinical staff must have an enhanced DBS check in place. The policy also

stated that staff likely to come into contact, but not provide care to, patients during the course of their duties e.g. receptionists; were required to have a standard DBS check, which was discretionary. We checked that reception staff who acted as chaperones, had DBS checks in place and records confirmed this.

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 helped 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 said these 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 medicine refrigerator was monitored and documented. The refrigerator was kept locked when not in use to help ensure that refrigerated medicines were kept safely and securely.

All prescriptions were reviewed and signed by a GP before they were given to the patient.

The nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. There were also appropriate arrangements to enable the nurse to administer medicines that had been prescribed and dispensed for patients. For example Vitamin B12 injections.

There was a robust 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.

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 GPs 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.

Emergency medicines were available in the practice and staff told us these were checked regularly. We saw records that confirmed this. All emergency medicines that we looked at were within their expiry dates. The practice kept clear records of how these medicines were checked, stocked controlled and reordered, if required.

Cleanliness & Infection Control

All the areas of the practice were clean and tidy. Patients told us they found the practice clean and tidy and said they had no concerns about the cleanliness of the premises.

Liquid hand wash and disposable towels were provided in the public toilets. There was a notice displayed in public areas that informed patients about the importance of hand washing to 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 disposable 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 staff as the infection control lead for the practice and we spoke with them. They 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 we saw evidence of training updates in infection control for all members of the clinical staff team. 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. Infection control audits were undertaken to monitor the cleanliness of the practice.

Are services safe?

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

Equipment

The practice had 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. 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 maintenance plan in use by the practice which took into account accessing alternative equipment in the event of equipment becoming faulty. There were records of issues with the premises and these showed that necessary repairs had been addressed quickly and patients had been informed of the actions taken. Records of portable appliance testing (PAT) of electrical appliances were seen during our visit.

Staffing & Recruitment

The practice had a recruitment policy that reflected the recruitment and selection processes completed by the practice. We looked at 10 staff files and saw that appropriate checks had been carried out for those staff employed after the practice had registered with CQC. For those staff who had been employed for over 10 years at the practice, there were plans to ensure that staff files contained appropriate supporting documentation, such as a curriculum vitae which showed the staff members full employment history and any gaps in employment.

Staff had a completed Disclosure and Barring Service (DBS) check, where the service had deemed it necessary and there were risk assessments in place for those staff who did require a DBS check. Records confirmed that checks with the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC) were carried out routinely to help ensure staff maintained their professional registration.

We spoke with the GPs and the management consultant about staffing levels within the practice. They told us there were strategies for the staff team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. The practice has had five of its 12 GPs leave within the last 12 months and has employed the services of a management consultant in order to support the practice with recruitment of GP's and other clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a 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.

Monitoring Safety & Responding to Risk

Weekly GP meetings were held and minutes of these meetings detailed how decisions were made about home visits and duty doctor arrangements, to help ensure there were sufficient hours provided for patient appointments, including emergency appointments.

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 of the partner GPs. 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 staff team. We looked at audits related to safety alerts and saw that these provided a clear audit trail of actions taken by the GPs to ensure patients safety. National data collected from incidents/events and alerts was monitored, assessed and used to improve patient safety within the practice.

The practice had a health and safety policy. Information was prominently displayed and included the details of the staff member responsible for health and safety. Risk assessments had been completed for the premises and were reviewed on an annual basis. These had also been updated to reflect any changes in identified risks within the practice that occurred before the annual review.

Are services safe?

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 emergency life support and emergency resuscitation. Staff told us they were aware of the procedures to follow in the event of an emergency.

The practice had medical oxygen and an automated external defibrillator (AED) for use in an emergency. The practice staff were able to demonstrate that they were fully equipped to deal with an emergency prior to the arrival of an ambulance.

The practice had both an emergency and business continuity plan. The plans included details of how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services, for example, extreme weather that caused staff shortages and any interruptions to the facilities available. Arrangements were recorded within the plans for patients to continue to receive care during such events. Appointments at the branch surgery were offered. The practice also had an agreement with other local practices to use their facilities, if patients were unable to attend the branch surgery.

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. GPs told us that patients received care according to national guidelines. The practice were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated and patients were discussed and required actions agreed. 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. For example, diabetes, heart disease and asthma.

Patients were offered care and treatment in accordance with nationally recognised standards. We were shown records of medicine audits that 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 patients with diabetes, following an update in best practice guidelines.

We spoke with clinical staff who told us that patients' health needs and potential risks were assessed at initial consultations with the GPs and nurses. Staff said that individual clinical and treatment plans were agreed and recorded on the practice's computerised system.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma 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. GPs and nurses told us this supported staff to continually review and discuss new best practice guidelines for the management of such health conditions.

Staff told us that 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 the age of 75 had a named GP who was responsible for overseeing their care and treatment.

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

The GPs, clinical nurse manager and administrative staff told us that registers were kept to identify patients with specific conditions/diagnoses. 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. We were told by a GP that they also carried out clinical audits which they used as evidence towards their appraisal. The practice showed us three clinical audits that had been undertaken in the last two years. These were incomplete audit cycles, however the practice was able to demonstrate the changes resulting from the initial audit. For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to manage diabetes, a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this medicine were not put at risk of being under or over dosed. The first audit demonstrated that a portion of patients reviewed were not receiving the recommended dose. The information was shared with GPs and patients were called for a medication review.

The GPs told us clinical audits were 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

Are services effective?

(for example, treatment is effective)

preventative measures). For example, we saw an audit regarding the prescribing of analgesics for patients presenting with sore throats. Following the audit, the GPs carried out medication reviews for patients who had been prescribed these medicines. The GPs had altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 602 of 607 clinical audits set by QOF had been completed in the year 2013/2014. The practice met all the minimum standards for QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

Effective staffing

There were processes for managing staff performance and professional development. Staff knew who was responsible for managing and mentoring them. We were shown records that confirmed all staff had completed basic life support (BLS), information governance, infection control, confidentiality and safeguarding children and adult training. The nurses and health care assistants had also completed specialist training in diabetes, asthma, family planning, travel vaccines, coronary heart disease, chronic obstructive pulmonary disease (a long-term respiratory disease) and updates in childhood immunisations. Clinical staff told us that they attended external meetings and events to help further enhance their continuing professional development. Records showed that staff received regular training updates. Staff said that they received annual appraisals and informal supervision. 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 as well as 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

Minutes of meetings demonstrated that the practice had established processes for multi-disciplinary working with other health care professionals and partner agencies. These processes helped ensure 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 nurses said that they attended quarterly meetings with the palliative care team to promote a united approach to patient care and treatments. Staff told us that where family difficulties were identified, referrals were made into the health visitor, who provided specialist support for mothers, babies, children and young people.

There were systems to process urgent referrals to other care and treatment services and to help 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 GPs as a priority.

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. Minutes of meetings held at the practice were recorded and made readily available to staff to refer to.

The practice was commissioned for enhanced services. For example, minor surgery and avoiding unplanned admissions to hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

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 in relation to unplanned/emergency admissions to hospital. The practice received discharge notifications and these were followed-up by GPs to review and plan on-going care and treatment where necessary.

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.

Are services effective?

(for example, treatment is effective)

GPs described how they discussed with individual patients and carers, which consultant to refer them to based on the patients' needs and individual preferences. GPs told us that they only occasionally used the 'choose and book' method for referrals. They told us that 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 or if it was deemed more appropriate for patients in meeting their on-going care and treatment needs.

We saw that an electronic patient record system was used by all staff to co-ordinate, document and manage patients' care. 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' records for future reference and used in planning on-going care and treatment.

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 patient's behalf.

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

Staff were aware of the Mental Capacity Act 2005, and we saw that some elements of the legislation were included in the safeguarding training that staff received. We spoke with GPs and nurses who demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. 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. For example where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making decisions for how, when and where to receive on-going care and treatment. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Staff told us that if they felt the patient lacked capacity to give 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. The procedures helped ensure patients who lacked capacity were appropriately assessed and referred where applicable.

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 alerted 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 that 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, chronic obstructive pulmonary disease and asthma. Staff told us that these clinics enabled the practice to monitor the ongoing condition and requirements of these groups of patients. They said the clinics also provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration. Patients who used this service told us that the practice had a recall system to alert them when they were due to re-attend these clinics and that appointments were flexible if they were unable to attend on a day, when a set clinic was being held.

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 would then be referred to the GPs.

Are services effective?

(for example, treatment is effective)

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 CCG and there were systems in place 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 the age of 65 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 staff at the practice were polite and helpful. Comments from patients were positive in relation to the care and treatment that they received.

All patients we spoke with considered their dignity and privacy had been respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained 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.

There were systems to help ensure that patients' privacy and dignity was protected at all times. The practice had a confidentiality policy which detailed how staff protected patients' confidentiality. Staff we spoke with were aware of their responsibilities in maintaining patient confidentiality. A room was available for patients to speak with reception staff in private if required. Telephone conversations that took place at reception could not be overheard by patients waiting for an appointment. Patients told us they felt their consultations were always conducted in a private and confidential manner.

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). Staff training records demonstrated they 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.

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.

Patients with children told us in their comment cards that the practice staff treated their children with the same respect as they would when speaking with adults. They commented that 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 planned treatment for their child.

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

Care planning and involvement in decisions about care and treatment

Patients we spoke with and comment cards completed, indicated they felt listened to and involved in the decision making process in relation to their care and treatment. They told us GPs and nursing staff took the time to listen to them and explained all treatment options available to them. They said they felt they were able to ask questions if they had any. Staff told us that patients could see the GP of their choice, although they acknowledged that patients sometimes had to wait a longer period of time if they wanted to see a specific GP. Patients were involved in decision making and had the time and information to make informed decisions.

Records demonstrated that care plans had been agreed between the patients and their families/carers for those patients with long term conditions. The practice maintained a 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 the patient's condition or medication having been amended. Clinical staff told us how they organised clinics for reviews of patients with care plans and how the appointment times were flexible to meet the needs of patients unable to attend on set clinic days.

Are services caring?

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 patents this service was available.

Patient / carer support to cope emotionally with care and treatment

Staff was 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 that 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 patients needs and individual preferences. GPs told us that 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 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. GPs and the management consultant told us that the frequency of these meetings had increased within the last year, in order to address issues that the practice were experiencing due to the loss of seven partner GPs.

The practice had a patient participation group (PPG) and a meeting had been conducted to discuss terms of reference and the purpose of the group. We saw that the practice were always looking at ways to recruit new members. We met with the vice chair of the PPG who told us that there are 12 members of the group and they were focused on health and wellbeing promotion, including specific items in the practices' newsletters and arranged sessions; communication and surveys. We were told that the group feel well supported, valued and listened too by the practice staff.

There were a range of services and clinics available to support and meet the needs of the varied patient groups. Staff told us they referred patients to community specialists or clinics, if appropriate. Examples of this were older patients, or their carers, referred 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. There were arrangements with another provider to deliver services to patients outside of the practice's working hours.

The practice worked closely with community nursing teams and the integrated care team who supported patients with long-term conditions and those with complex needs who received care and treatment. Patients told us that 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 premises were accessible for patients with disabilities. The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. There were ramps to gain entry into the practice and appropriate parking spaces close to the entrance door. There was lift access to the first floor. There was a designated toilet available for people with disabilities. The reception desk had a low level section to accommodate patients using wheelchairs. Interpretation services were available by arrangement for patients who did not speak English. 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

Patients booked an appointment by telephone, online or in person. Appointments were available on Monday, Tuesday, Wednesday and Friday 8.30am to 12.30pm and 1.30pm to 6.30pm, Thursday 8.30am to 12pm and 1pm to 6.30pm. Extended surgery hours are available on Wednesday evenings after 6.30pm and on Saturdays 9am to 11.30am. The practice offered pre-bookable appointments in advance and appointments on the same day. Staff told us 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

Are services responsive to people's needs?

(for example, to feedback?)

prioritise appointments for them. The reception staff we 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 said that access to urgent or emergency appointments met their needs and expectations.

Patients we spoke with and those who had completed comment cards, told us they experienced difficulties when using the telephone appointment booking system (for contacting the practice for an appointment on the same day). 30 of the 32 patients we spoke with and 16 of the comments cards received, raised concerns about accessing appointments and long waiting times once at the practice. On the day of our visit we observed that there were long queues of patients waiting at the door in the mornings, these patients told us they wanted to get an appointment. Two patients told us they now come in person to get an appointment rather than call because it was so difficult to get an appointment on the phone. Patients said they had to commit an hour to continually phoning in order to get an appointment and that quite regularly; they would get through on the phone and then be told that all appointments for that day had been booked and they would need to try again tomorrow.

A patient survey conducted by the PPG in February to March 2014 showed significant issues with the appointment booking process, either online, by telephone or at the reception desk. From minutes of meetings and our discussion with the vice chair of the PPG, we observed that the PPG had recognised that the practice was going through a state of change and were supporting the practice by focussing on how to get messages about changes across to the patients/public.

We spoke with the GPs and management consultant and were told that they had found the loss of seven of their 12 partners had impacted significantly on appointment bookings and waiting times. As a result the partners had met with the local area commissioners to assess, review and plan how the service could continue to meet the needs of patients and any potential demands in the future. The practise business plan included actions that the partners wished to take to resolve the issues around booking appointments and waiting times. For example, nurse managed home visits and nurses and/or paramedics managing day to day walk in and emergency clinics, as well as chronic disease management clinics. We were told that recruitment processes had been implemented in order to recruit staff to fulfil the roles for providing these additional clinics.

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

There were arrangements that helped 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, on the outside doors of the practice, 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 that 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 there was a designated responsible person who handled all complaints in the practice.

Practice meeting minutes demonstrated complaints were discussed. The complaints procedure was also included in the practice information booklet for patients. The majority of patients we spoke with told us that 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. Two patients told us that they had had cause to complain in the past and that their complaint was taken seriously, that they were informed of all stages of any subsequent investigation and the conclusion/outcome of their findings.

We looked at five complaints received in the last 12 months. Records demonstrated complaints were investigated and the outcome of each investigation was sent to the respective complainant. Contact details of the ombudsman were also included. This gave patients the option of taking their complaint further if they were not happy with the way in which the practice responded. There

Are services responsive to people's needs?

(for example, to feedback?)

was also a log of all informal complaints received by the practice. 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 that 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 and business plan to inform individual or team objectives and the management team promoted an inclusive approach to achieve its purpose of providing good quality care to all patients. All members of staff that we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The governance arrangements at the practice included the delegation of responsibilities to named GPs, for example, a lead 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.

In the absence of the practice manager, the office manager and management consultant were responsible for human resource policies and procedures. We reviewed a number of policies that supported staff in their roles. For example, 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. The staff we spoke with told us they felt there was an 'open door' culture and that the GPs and practice manager were approachable. They told us that 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 both open and inclusive. Staff told us that 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 how services were provided. Staff said they felt their views and opinions were valued and that there was good communication and team work within the practice. Staff told us they attended and participated in regular staff meetings that included discussions about changes to procedures, clinical practice, and staff cover arrangements. However, they told us that meetings were organised per staff group. For example, GP meetings, nursing and healthcare assistant meetings and administrative staff meetings. Staff told us that due to the recent loss of staff, including the practice manager, there were no formal meetings for the staff team to meet collectively and they felt this impacted on the way the individuals staff teams communicate with each other.

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.

The practice worked effectively with the patient participation group (PPG) and used feedback and information from PPG patient surveys to improve services, care and treatment that was provided. Records demonstrated that patients verbally reporting issues/

Are services well-led?

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

concerns had been addressed by the practice, these included the feedback given to patients following any action taken. Patients we spoke with and those who completed comment cards told us they were happy to speak with staff 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 that training updates provided them with information on current best practice and 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 management consultant 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, as well increasing demands on the reduced number of GPs. The 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 records (so they relate to specific diagnoses) 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 that helped to ensure GPs received an annual appraisal and records showed that the GP revalidation process had been implemented at the practice.