Dr Ahmad and Partners

Quality Report

Platt Bridge Health Centre
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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 inspected Dr Ahmad and Partners on 10 November 2014. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We assessed all six of the population groups and the inspection took place at the same time as we inspected a number of practices in the area overseen by Wigan and Leigh Clinical Commissioning Group (CCG).

The overall rating for Dr Ahmad and Partners was good.

Our key findings were as follows:

- Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our visit. A system was in place for managing Infection prevention and control.
- The practice had systems in place to ensure best practice was followed. This is to ensure that people's care, treatment and support achieves good outcomes and is based on the best available evidence.
- Information we received from patients reflected that practice staff interacted with them in a positive and empathetic way. They told us that they were treated with respect, always in a polite manner and as an individual.
- Patients spoke positively in respect of accessing services at the practice. A system was in place for patients who required urgent appointments to be seen the same day. Patients accessed appointments by telephone as the practice did not have a web site.

We found an area of outstanding practice. Patients with a higher risk of an unplanned hospital admission had a care plan in place that was regularly updated. The practice had an arrangement with the ambulance service so that if they attended a patient with a care plan during the opening hours of the practice they telephoned a GP for advice to try to avoid a hospital admission.

There were however also areas of practice where the provider needs to make improvements.

The provider should:

Summary of findings

- We saw no evidence of the practice nurse having a formal appraisal meeting for several years.
- Although all staff knew the procedure they should follow if they had a safeguarding concern not all clinical staff had received formal training.
- When a patient did not speak English family members were routinely used to interpret during consultations. Consideration had not been given about to ensuring the correct information was given to the patient or that the patient was able to give informed consent.
- There was no female GP available and patients reported that at times they would prefer to see a female GP.

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 and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles. Records of appraisals for the majority of staff were available. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were usually involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. Some reported that they would prefer to see a female GP at times but only male GPs were available. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. Staff were clear about their roles and responsibilities. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and regularly attended staff meetings.

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

Outstanding 

The practice is rated as outstanding for the population group of older people. The practice offered proactive personalised care to meet the needs of older people in its population. They had a high percentage of patients who lived in residential or nursing homes. They were in the process of ensuring all these patients had a care plan in place to help them avoid unplanned hospital admissions. Where a patient with a care plan either had an ambulance called or attended the hospital accident and emergency department arrangements were in place to contact the GP. This system that the practice had put in place meant more patients were able to receive care and treatment without having to be admitted to hospital. with a view to managing their symptoms without the need for a hospital admission. Patients in this population group reported easy access to appointments. We also saw home visits were routinely offered to patients who found it difficult to attend the practice, with all visits to carry out the annual flu vaccinations being completed. Health checks were offered to all patients over the age of 75 and these patients were also allocated a named GP.

People with long term conditions

Good 

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed patients were offered longer appointments, and home visits were also available. All these patients had a structured annual review to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good 

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. GPs understood the Gillick competencies. We were provided with good examples of joint working with midwives and health visitors. Children were always seen on the day a GP appointment was requested.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 offer continuity of care. The practice was open late one evening each week, and telephone appointments could also be arranged. Patients between the ages of 40 and 70 were invited for a health check.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register for patients with learning disabilities. They did not have any homeless people or travellers registered with them. Patients with learning disabilities were invited for an annual health check. If they did not attend this appointment following several contacts arrangements were in place for them to be referred to the CCG to follow up their needs. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group 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 in place care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. Counselling was available and a psychological therapist was based in the building. GPs worked as part of an integrated neighbourhood. Staff had received guidance during practice meetings on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 31 completed patient comment cards and spoke with 10 patients at the time of our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed our comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They also told us that they were treated with respect and that their privacy and dignity was maintained.

We also looked at the results of the 2014 national GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

91% of respondents describe their experience making an appointment as good.

87% of respondents said they would recommend the practice to someone new to the area.

97% of respondents said the appointment they had was convenient.

Areas for improvement

Action the service SHOULD take to improve

- We saw no evidence of the practice nurse having a formal appraisal meeting for several years.
- Although all staff knew the procedure they should follow if they had a safeguarding concern not all clinical staff had received formal training.
- When a patient did not speak English family members were routinely used to interpret during consultations. Consideration had not been given about to ensuring the correct information was given to the patient or that the patient was able to give informed consent.
- There was no female GP available and patients reported that at times they would prefer to see a female GP.

Outstanding practice

Patients with a higher risk of an unplanned hospital admission had a care plan in place that was regularly updated. The practice had an arrangement with the ambulance service so that if they attended a patient with a care plan during the opening hours of the practice they telephoned a GP for advice to try to avoid a hospital admission.

Dr Ahmad and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a GP specialist advisor and a practice manager specialist advisor. Our inspection team also included an Expert by Experience who is a person who uses services themselves and wants to help CQC to find out more about people's experience of the care they receive.

Background to Dr Ahmad and Partners

Dr Ahmad and Partners is situated in the Platt Bridge area of Wigan. At the time of our inspection 6350 patients were registered with the practice. It was the second largest practice, in terms of the number of patients registered, in the Clinical Commissioning Group (CCG) area and it had the highest number of patients living in residential or nursing homes in the CCG area.

The practice population experiences higher levels of income deprivation, especially effecting children and older people, than the practice average across England.

At the time of our inspection there were three GP partners and a long term locum GP. These were all male. There were two practice nurses, a healthcare assistant and an administration team that were led by a practice manager.

The practice delivers commissioned services under a General Medical Services (GMS) contract.

Dr Ahmad and Partners had opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider.

Why we carried out this inspection

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

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
- The working-age population and those recently retired (including students)

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 10 November 2014. We reviewed all areas that the practice operated, including the administrative areas. We received 31 completed patient comment cards and spoke with 10 patients during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with GPs, a practice nurse, the healthcare assistant, the practice manager and members of the reception team.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. These included national patient safety alerts, comments and complaints made by patients, and reported incidents. There were clear lines of leadership and accountability in respect of how significant incidents, including mistakes, were investigated and managed. Before our inspection we reviewed a range of information we held about the practice and asked other organisations such as NHS England and Wigan Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

We saw evidence that significant events were escalated to the appropriate body, such as NHS England or the CCG. The staff we spoke with were all aware of how to report significant events. They told us that significant events, including the investigation, outcome and learning points, were discussed at practice meetings. The safety records we reviewed showed us the practice had managed them consistently over time and could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw the records of significant events recorded since 2010. The examples we looked at provided evidence of how incidents were investigated and the how action required to address the risk and minimise it or prevent it from reoccurring was identified.

The staff we spoke with told us there was an open culture and they were encouraged to report incidents or mistakes. They said they received support to do this, and all staff, including receptionists, were aware of the procedure to follow. Staff told us learning from significant events was discussed at practice meetings as a regular agenda item. These meetings were held every month and most staff attended them. Where a staff member did not attend a meeting arrangements were in place to ensure they knew what had been discussed.

The practice had a system in place for managing safety alerts received from external agencies. These were reviewed by the GPs, practice nurse and practice manager and action was taken where appropriate to do so.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GP partners was the lead for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and liaising with external safeguarding agencies, such as the local social services and CCG safeguarding teams and other health and social care professionals as required. We discussed how safeguarding was managed at the practice and looked at the systems used to ensure patients safeguarding needs were addressed.

In line with good practice the safeguarding lead had completed level 3 (enhanced) training in safeguarding adults and children. All the staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. They also showed us that information was on the desktop of their computers so they could access guidance at any time. There were flowcharts in each surgery to prompt staff about the process to follow, and also to give inform ion about who to contact if they had any safeguarding concerns. We saw that non-clinical staff had received safeguarding training, but not all the clinical staff had been trained. The practice manager told us this was being arranged.

We saw evidence that where a GP had safeguarding concerns they reported it to the relevant authority. We saw they kept a record of the action that had been taken and ensured their concerns were dealt with promptly and appropriately.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. No issues in respect of chaperoning were raised by patients we spoke with or received information from. On occasions reception staff carried out chaperone duties. We saw that a Disclosure and Barring Service (DBS) check had been carried out for all staff to ensure they were suitable for this role. Staff had been trained in chaperoning and knew their role and responsibilities.

Good

Are services safe?

Medicines Management

We checked the medicines stored in the treatment rooms and medicine fridges. These included vaccines that needed to be stored within a specific temperature range. All medicines were securely stored and all within their expiry date. Appropriate medicines were held for use in an emergency. The temperature of the medicines fridges were monitored on a daily basis by the practice nurse, but other staff were also aware of the required procedure. A record was kept of these checks. Staff knew what action to take if the temperature was outside the required range, and we saw instructions were also kept with the temperature check record for staff to refer to.

There were systems in place for the management, secure storage and prescribing of medicines within the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions.

GPs told us they did not routinely store medicines in their bags to take on home visits. Prior to a home visit they assessed the need for emergency medicines and took them if they were required. GPs told us they were within easy reach of a hospital and pharmacies if medicines were required, but their risk assessments were usually accurate.

Every week a prescribing advisor from the CCG attended the practice. They checked the prescribing within the practice and provided advice and updated information when required. This included information about medicines that should not be prescribed together.

Cleanliness & Infection Control

During our inspection we found the practice to be visibly clean and uncluttered. Systems were in place for ensuring the practice was regularly cleaned. Cleaners were employed by the owners of the building, and they were based on-site. They attended the practice in the morning and at night, and were available if there were any spillages during the day. We saw the practice also had spillage kits they could use themselves. There was a cleaning schedule in place covering all aspects of cleaning the practice. The practice manager and the cleaners' management team ensured cleaning was carried out to the required standard.

The practice nurse was the lead for infection control at the practice. Staff had not received formal training in the prevention and control of infection, but an infection control specialist from the CCG had met with the infection control lead to give advice. We also saw evidence that guidance had been provided during practice meetings. We saw that appropriate hand washing facilities, including liquid soap and disposable towels, and hand washing instructions were available throughout the practice. Audits had been carried out to ensure actions taken to prevent the spread of potential infections were maintained. The last one had been carried out during the month of our inspection, and we saw plans were in place for any areas where improvements had been identified as necessary.

Throughout the practice equipment to protect staff from exposure to potential infections, such as disposable gloves, aprons and goggles were readily available.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a specialist company for safe disposal. We saw records that detailed when such waste was removed.

The management, testing and investigation of legionella was managed by the owners of the building. We saw that there was a system I place to ensure water was run regularly for the appropriate time in rooms that were not in use for over a week.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example weighing scales and blood pressure monitors, being carried out.

Staffing & Recruitment

The practice was staffed to enable the personal medical service needs of patients to be met. The staff team were well established and most had worked at the practice for many years. We saw that every morning at 9am the GPs checked the demand for appointments for the day. Where there was an increased demand we saw they increased their availability so additional telephone or face to face

Good

Are services safe?

appointments could be made. The practice manager kept a staff rota which they updated at least every month. We saw that this included when staff, including clinicians, were available. The practice manager could see at a glance if there were enough staff available to meet the needs of the patients, and alternative arrangements could be made if necessary.

We saw the policies in place relating to the recruitment of staff. Most of the essential points were covered but the circumstances when a DBS check would be carried out for staff was not included in the policies.

We looked at the personnel records for a selection of staff, including clinical and non-clinical staff.

A full employment history, references and proof of identity had been kept. We also saw that DBS or Criminal Records Bureau (CRB) checks had been carried out for all staff. A check had been carried out to ensure that clinicians were registered with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC).

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that all staff received annual basic life support training. We looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. The practice manager told us that although they carried out regular walk arounds of the practice to ensure all aspects of it were safe, they did not keep a record of this. Appropriate action was taken to respond to and minimise risks associated with patient care and premises.

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

We saw fire safety checks were carried out with weekly alarm tests and full fire drills were scheduled by the building manager. The building management had fire marshalls in place that ensured in the event of an emergency staff and patients were able to evacuate the building safely.

Emergency equipment including a defibrillator and oxygen were easily accessible, and staff had received training in how to use the equipment. Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that people's care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), guidance published by professional and expert bodies, and within national health strategies were used to inform best practice at the practice. We saw that such standards and guidelines were easily accessed electronically by a named GP. They then disseminated the information to other staff within the practice. We saw evidence in the minutes of meetings that this dissemination took place routinely.

Discussion with GPs and looking at how information was recorded and reviewed, demonstrated that patients were being effectively assessed, diagnosed, treated and supported. GPs and other clinical staff conducted consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

A prescribing advisor from the Clinical Commissioning Group (CCG) attended the practice weekly to check prescribing and provide advice and information. We saw this information was given to all relevant staff. Audits were also carried out to assess the effectiveness of the service.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. There were quality improvement processes in place to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with the CCG. We saw evidence of the clinical audits cycles that had been carried out. These included the prescribing of certain medicines and the risk of stroke in patients with atrial fibrillation. The audit cycles showed there had been a positive outcome for patients.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. One of the GPs also attended a monthly CCG GP Forum meeting to keep up to date with any changes in the area. Information was then disseminated to other relevant staff.

The GPs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as palliative care, children and safeguarding children and vulnerable adults. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Effective staffing

Staff training records and discussions with staff demonstrated that all grades of staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. New staff, including clinical staff, were provided with a programme of induction that included training relevant to their role.

We saw that most staff had had an appraisal with their line manager in the previous 12 months. Staff told us they were asked to complete a pre-appraisal questionnaire and following their appraisal meeting a personal development plan was put in place. They said they felt supported by their line manager, and were able to access all appropriate training.

We found no evidence of one of the practice nurses, who was not present during the inspection, having an appraisal for several years. The practice manager told us the nurse had been appraised by a GP but they did not know if it had been documented.

Good

Are services effective?

(for example, treatment is effective)

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. We saw that the GPs were up to date with their appraisals.

Working with colleagues and other services

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective, co-ordinated and integrated care.

The patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. They told us referrals were made in a timely manner.

We saw that a psychological therapist, health trainers, and a smoking cessation service were based in the building. The practice worked closely with them and referred patients if required.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. They regularly met with professionals such as health visitors and Macmillan nurses to plan and coordinate the care of patients.

Patients with a higher risk of having an unplanned hospital admission had a care plan in place. The practice had an arrangement with the ambulance service. If the ambulance service attended a patient who had a care plan during times the practice was open they telephoned to speak with a clinician with a view to avoiding taking the patient to hospital. If a patient with a care plan in place attended the hospital accident and emergency department during working hours their GPs were contacted for advice as required. The practice were monitoring the effectiveness of this system and early results were positive.

Where a patient attended the out of hours service the practice was informed within 24 hours. If a patient was nearing the end of their life or had complex health needs a statement of intent was provided for the out of hours service so they had relevant information if they were contacted. The out of hours service was also contacted if a patient was being over-prescribed medicines. This was to prevent further medicines being prescribed.

Information Sharing

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice. We saw examples with this when looking at how information was shared with local authority and CCG safeguarding teams.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The 2014 GP patient survey reflected that 72% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in decisions about their care. This was below the average score for the CCG area. The practice scored higher than the CCG average for the last GP the patient saw or spoke to being good at explaining tests and treatments and for the last nurse the patient saw or spoke to was good at explaining tests and treatments.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. People were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Clinical staff we spoke with clearly understood the importance of obtaining consent from patients and were able to describe when written consent was to be sought, or consent documented on the patients' notes. All clinical staff demonstrated a clear understanding of the Gillick competencies. This helps a clinician decide if a young person aged 16 or younger is abke t consent to their own medical treatment without the need for parental permission.

We saw the consent policy and protocol that was in place. This gave clear guidance to staff about all areas of consent.

Good

Are services effective?

(for example, treatment is effective)

It stated that clinicians should ensure consent was given freely and not under duress, for example from other present family members. However, family members were on occasions used as interpreters. Consideration had not been given about how this was managed when ensuring a patient had given their consent.

Health Promotion & Prevention

We saw that new patients registering with the practice were offered a new patient appointment with the healthcare assistant. This included taking a medical and family history, checks on blood pressure, height and weight, alcohol consumption and smoking status and a lifestyle discussion. If there were any areas of concern or an increased health risk was identified a referral could be made to the GP or practice nurse.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Patients between the ages of 40 and 70 were invited for a health screening appointment. Their risk of developing a long term illness was assessed and a discussion took place around their lifestyle to see where improvements could be made. Patients who had not attended the practice for any appointments for five years were also invited to attend for a health check.

All patients over the age of 75 were also invited to attend a health check, along with patients who frequently attended hospital. The practice had a high proportion, 22%, of its patients living in residential or nursing homes. They were putting in place a care plan for all patients who lived in one of these homes and at the time of our inspection around half were completed. The community matron visited the high risk patients in residential homes, as identified in the care plans. The care plans were in place to reduce hospital admissions.

We saw that the practice had almost completed its flu vaccination programme. Housebound patients had been identified and had received a visit to ensure they had received their vaccination. The practice nurse told us that when a patient had not attended for their vaccination they telephoned them to prompt a new appointment.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we spoke with 10 patients and received 31 CQC comments cards completed by patients of the practice. Most feedback was extremely positive. The patients we spoke with told us they were treated with respect and in a polite manner by all staff. Seventeen of the comments cards specifically stated that staff were very polite and treated them with kindness. Patients commented that reception staff went out of their way to accommodate patients' requests.

We observed staff to be respectful, pleasant and helpful. The staff we spoke with were highly motivated and told us they were encouraged to find ways of meeting the needs of patients.

Patients told us there privacy and dignity were always maintained during consultations. All patient appointments were carried out in the privacy of an individual consulting room. We saw that privacy curtains were around examination couches and most patients told us they were offered a chaperone if they required an intimate examination.

There was no female GP at the practice and some patients commented that this was a problem and there were times when they would prefer to see a female GP. The practice manager told us they were trying to recruit a female GP to work for one session each week. They said that practice nurses were utilised on some occasions when it was appropriate to do so, and one of the practice nurses was a trained midwife.

We looked at the results of the 2014 national GP patient survey. The results showed that 77% (lower than the average for the CCG area) of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern, and 84% (higher than the average for the CCG area) said the same of the last nurse they saw or spoke to.

Care planning and involvement in decisions about care and treatment

The 2014 GP patient survey reported that 72% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care, and 77% of respondents said the same of the last nurse they saw or spoke to. The figure for GPs was lower than the CCG average for the area and the figure for nurses was higher.

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon.

We saw that a wide range of information about various medical conditions was available in the reception area. Information about services that were available in the area was also displayed.

Where patients and those close to them needed additional support to help them understand or be involved in their care and treatment the practice had taken action to address this. Extended appointment times were given when the need was anticipated. These included where a patient had a learning disability and more discussion and explanation would be required. All the clinicians we spoke with were aware of their responsibilities under the Mental Capacity Act 2005.

The practice were able to access interpreters where one was required. However, the practice manager and GPs told us they had not used the facility. They told us that most patients were able to understand some English, and the patients who needed an interpreter usually brought a family member with them. However, the practice had not considered that there could be some circumstances where accurate translation may be provided by a family member, and patients' family members may in effect make decisions on behalf of patients without their knowledge.

Patient/carer support to cope emotionally with care and treatment

The practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken action to identify and support patients' carers.

A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians and in the reception area.

A counsellor attended the practice once a week. There was an average wait of four to six weeks for a fist appointment but we saw patients were given an early telephone

Good

Are services caring?

assessment so those with an urgent need could be seen quicker. The practice also had access to anger management, bereavement and marriage guidance counselling. Patients had access to groups such as children of parents with alcohol misuse and pregnancy support. The local drug and alcohol team attended the practice each week.

The patients we spoke with told us their emotional needs were met by the practice. Some had been offered counselling, and those that attended it found it helpful. Patients told us they felt listened to and supported by all staff at the practice, and the comments made by patients on comments cards also mentioned this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that meet patient's needs. The practice was part of a federation of eight practices. The practice manager told us this was useful as some conditions could be investigated in-house, but patients could also be referred to a practice within the federation who were better placed to diagnose and treat the condition.

We saw there was an integrated neighbourhood programme that the practice participated in. GPs met with other professionals such as social workers and mental health services, and GPs from two other practices, every month. They looked at holistic issues, such as housing problems faced by patients, and put plans in place for patients at risk.

The GPs took the lead for specific conditions such as dementia and chronic diseases and the areas of safeguarding adults and children. There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. Also medicine reviews were arranged at appropriate interval for patients who required regular medicines.

The practice kept a register of patients with a learning disability. They were invited for an annual health check. If they did not attend following contact by letter and telephone the Clinical Commissioning Group (CCG) learning disability coordinator was informed so further contact could be made.

Al patients over the age of 75 were given a named GP. One patient we spoke with told us they had attended an over 75 health check and been told about their named GP at the same time. They told us they found it helpful knowing who they should approach if they have any issues.

Where a patient had a higher risk of unplanned hospital admittance and they had a care plan in place and alert was on their electronic records. This meant that when they contacted the practice staff were alerted to their increased risk and appropriate action could be taken.

Most patients told us they could usually access an appointment with the GP of their choice. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. There was no female GP at the practice. The practice manager told us they were hoping to recruit a female GP to work one session each week so that patients could have access to a female GP at certain times.

We saw that longer appointments were available for patients when required. They were routinely made for patients with long term conditions. We saw evidence that GPs and the practice nurses conducted home visits to patients whose illness or disability meant they could not attend the practice.

Tackle inequity and promote equality

The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care. The practice manager told us they had no registered patients who were homeless or travellers. Staff told us that although some patients did not speak English as a first language most spoke some English. They told us that patients preferred to bring a family member to translate for them and they did not tend to use the telephone interpreter service that was available. The practice was able to access information in Braille and they told us this was regularly used for their blind patients.

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

Access to the service

We spoke with 10 patients during our inspection. Six of those told us they had made their appointment either on the same day they attended or the previous working day. The patients we spoke with told us it was easy to make appointments and in an emergency they were seen on the day they requested an appointment. One patient commented that it was sometimes difficult to get through to the practice on the telephone but if they called in person they were given an appointment within an appropriate

Good

Are services responsive to people's needs?

(for example, to feedback?)

timescale. The comments by patients on the CQC comments cards also stated that access to appointments was not a problem. The results of the latest national GP patient survey showed that 91% of respondents found the experience of making an appointment as good. This was above the CCG average for the area of 79%.

The practice manager explained the appointments system to us. In most cases patients spoke with a clinician who assessed the need for an on the day appointment. We saw evidence that the GPs made further on the day appointments available if there was a need. If required, an appointment was made. It was acknowledged that not everyone who requested a same day appointment could be accommodated, but the system meant that those in need were seen by a GP. GPs told us that where a patient requested an urgent appointment for a child this request was always met. Appointments could be pre-booked until the end of the month following our inspection. Telephone appointments were also available. We saw that the earliest available pre-bookable appointment was for the morning following our inspection.

The opening times of the practice were prominently displayed in the practice, and also available in the practice leaflet and on the website. Appointments were available until 8.15pm one evening each week. Information about where medical assistance could be sought when the practice was closed was readily available to patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for managing complaints. The process was not overseen by a GP. We saw that all complaints, whether made in writing or verbally, were recorded. Very few complaints had been made, and all complaints were appropriately investigated and a full response was given.

Although information about how to make a complaint was available in the waiting area and on the website, eight of the 10 patients we spoke with told us they would not know how to make a complaint to the practice. All the staff we spoke with were aware of the complaints process and told us they would inform the practice manager if any patient expressed dissatisfaction.

Are services well-led?

Good

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

Our findings

Vision and Strategy

There was a well-established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice team. One partner was semi-retired and did not have many patient consultation sessions. However, a long term locum GP was working at the practice. There were no long term plans for the practice and no succession planning in place for when GPs retired.

GPs and the practice manager met regularly with the Clinical Commissioning Group (CCG) to discuss current performance issues and how to adapt the service to meet the demands of local people. The GPs were committed to providing a high quality service to patients in a fair an open manner. Our discussions with patients and staff demonstrated that these values and targets were being met.

Governance Arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. There were monthly meetings held, both for clinical staff and all staff. Specialists attended these meetings to give staff information about various matters. For example, in September 2014 a respiratory consultant attended a meeting to give staff an overview of chronic obstructive pulmonary disease (COPD), and in August 2014 a member of an Alzheimer's support group attended to give staff information.

We looked at the minutes of recent meetings. These provided evidence that performance, quality and risks had been discussed and any required actions were monitored.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. The clinical audits we saw showed that they had had a positive impact on patient outcomes.

The governance and quality assurance arrangements at the practice combined with the open and fair culture enabled risks to be assessed and effectively managed in a timely way. By effectively monitoring and responding to risk patients and staff were being kept safe from harm.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure which had named members of staff in lead roles. We spoke with staff members and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. The staff team had worked together for many years and there was a very low turnover of staff and a low sickness rate.

We saw that practice staff meetings were held for all staff every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings, individual appraisal meetings or during the regular informal discussions that took place. They said the practice manager had an open door policy and was very approachable, as were the GPs.

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

The practice carried out patient satisfaction surveys. The most recent survey showed that 95% of patients who responded rated the practice as good, very good or excellent. Where issues had been identified action had been taken to address them. We saw an action plan had been put in place and this was monitored by the practice manager. Telephone access had been highlighted as an issue by patients. As a result the telephone system had been changed to avoid patients having to wait in a queuing system for lengthy periods. The practice had also started to carry out an exit survey for patients. The main issue identified on this shorter survey was telephone access and the practice manager was looking at ways this could be improved.

The practice had an active patient participation group (PPG). Approximately 17 patients regularly attended the PPG meetings, that were held approximately every three

Are services well-led?

Good

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

months. The practice manager and the members of the PPG we spoke with told us 15 of the 17 were retired people and they struggled to find younger patients to make the group more representative of the practice population. The group discussed the results of surveys and put forward ideas for improvements within the practice. The members of the PPG we spoke with told us they felt listened to and they though the practice valued their opinions.

The staff we spoke with told us the practice manager had an open door policy and they were encouraged to make suggestions about how the service could be improved. There were opportunities to put forward their ideas during the regular practice meetings, and also during their more formal appraisal meetings.

Management lead through learning & improvement

Staff told us they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. They said they were supported in their personal development.

We saw evidence that the continuing professional development (CPD) of the practice nurses was monitored and recorded. They were able to obtain clinical advice from any of the GPs at the practice.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), indicated that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved.