Dr Rashid Akhtar

Quality Report

The Surgery
Sundial Lane
Great Barr
Birmingham
West Midlands
B43 6PA
Tel: 0121 358 0082
Website:

Date of inspection visit: 29 October 2015
Date of publication: 21/01/2016

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

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 7

Areas for improvement 7

Detailed findings from this inspection

Our inspection team 8

Background to Dr Rashid Akhtar 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Rashid Akhtar on 29 October 2015. Overall the practice is rated as good.

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

- Incidents were being reported and learning shared with staff. There were systems in place to maintain the health and safety of patients and staff at the practice.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards. The practice was proactive in promoting good health.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice premises were acknowledged as a challenge to providing privacy in the reception area and plans were in place to overcome this.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

The areas where the provider should make improvement:

- The practice should consider how they ensure patients are aware of the extended opening hours.
- Develop a stock control system to record medicines that are kept in the surgery.
- The practice should have the equipment to meet all emergncies
- Ensure business continuity plan is robust

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. There was an effective system in place for reporting and recording significant events which were shared with staff in team meetings to prevent reoccurrence. Equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained. The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. Risks to patients were assessed and well managed and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and patients' needs were assessed and care was planned and delivered in line with current legislation. The practice carried out clinical audits to demonstrate quality improvement. Systems were in place for regular reviews of patients who had long term conditions. Staff had received training appropriate to their roles and the practice could show that appraisals and had been completed for all relevant staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients we spoke with told us they were satisfied with their care and they had confidence in the decisions made by clinical staff. The comment cards patients had completed prior to our inspection provided positive opinions about staff, their approach and the care provided to them. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. The practice building posed a challenge to maintain confidentiality and staff were aware of this. Where possible staff worked to maintain confidentiality especially in the reception area.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients had access to screening services to detect and monitor certain long term conditions. There were immunisation clinics for babies and children. The practice had recognised through patient surveys any improvements and was responding to them. Patients

Summary of findings

said they found it easy to make an appointment and that there was continuity of care as there was one lead GP. Urgent appointments available the same day as well as home visits and telephone consultations. Although the practice had been purpose built, the premises posed a challenge to meet some of the needs of the patients such as maintaining privacy. However, staff worked around the limitations to which they tried to meet. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from patients, which it acted on. There was a patient participation group which met every six months. Staff were involved in the analysis of incidents and complaints during meetings for on-going improvements that benefitted patients. There was a governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. There was evidence of improvements made as a result of audits.

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. Nationally reported data showed that outcomes for patients were similar for conditions commonly found in 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had a higher than average elderly population with higher prevalence rates for some diseases compared to local and national average. Data showed that the practice's achievement for the management of long term conditions was slightly lower than local and national average. However, the practice recognised the reason for this and had implemented a strategy to ensure better outcome. This included more review session with nursing staff that had lead roles in chronic disease management. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. The clinical team offered immunisations to children in line with the national immunisation programme. The practice provided extended opening hours every Saturdays jointly with two other practices locally. Consultations were held at another surgery nearby and GPs from each practice took turns for Saturday consultations. This allowed children and other patients who would be unable to visit the practice during normal working hours to attend. All consultation rooms were on the ground floor which made the practice accessible for pushchairs.

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 practice provided extended opening hours on Saturday mornings for patients who were unable to visit the practice during normal working hours. The practice also had arrangements for patients to have telephone consultations with a GP. The practice was proactive in offering a full range of health promotion and screening that reflected the needs of this age group. This included health checks for patients aged 40 to 70 years of age.

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 those with a learning disability. It had carried out annual health checks for patients with a learning disability and most of these patients had received a follow-up. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Home visits were carried out to patients who were housebound and to other patients on the day that had a need. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Joint clinics with the GP and a consultant in diabetes were held every three months at the practice.

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). Ninety percent of people experiencing poor mental health had received an annual physical health check with a completed plan of care. Seventy four percent of patients with dementia had received at least one review so far this year. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 8 July 2015. The results showed the practice was performing above local and national averages. 269 survey forms were distributed and 106 were returned.

- 95% found it easy to get through to this surgery by phone compared to a CCG average of 63% and a national average of 73%.
- 95% found the receptionists at this surgery helpful (CCG average 82, national average 87%).
- 85% were able to get an appointment to see or speak to someone the last time they tried (CCG average 77%, national average 85%).
- 93% said the last appointment they got was convenient (CCG average 89%, national average 92%).
- 83% described their experience of making an appointment as good (CCG average 64%, national average 73%).
- 94% usually waited 15 minutes or less after their appointment time to be seen (CCG average 84%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were all positive about the standard of care received. All comments were positive about the service and staff. Patients commented that staff were helpful, welcoming, polite and caring.

We spoke with three patients during the inspection. All three patients said that they were happy with the care they received and could get an appointment when needed.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement:

- The practice should consider how they ensure patients are aware of the extended opening hours.
- Develop a stock control system to record medicines that are kept in the surgery.
- The practice should have the equipment to meet all emergncies
- Ensure business continuity plan is robust

Dr Rashid Akhtar

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Rashid Akhtar

The practice has approximately 3000 patient registered. It is open from 8.30am to 6.30 pm Mondays to Fridays. We were told that the practice provided consultations on Saturday mornings held at another surgery nearby. The practice worked with two other local surgeries and a GP from each practice took turns to hold clinics on Saturdays. Appointments were open to patients from the three practices. However, this was not advertised in the practice reception area or leaflet.

The practice went on to a General Medical Services contract (GMS) with NHS England from April 2015. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some directed enhanced services such as minor surgery, childhood vaccination and immunisation schemes as well as facilitating timely diagnosis and support for people with dementia. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice has two GPs, one lead GP (male) and a locum GP (female) who worked one session a week. There is practice nurse who worked 4 days and a healthcare assistant who worked on Wednesdays for three and a half hours. The practice team also consisted of a practice manager, a secretary who covered the practice manager when on leave and a team reception staff.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in an area with a low deprivation score compared to other practices nationally. Data showed that the practice has a higher than average practice population aged 45 years and over in comparison to other practices nationally. The practice also has a lower than national average population aged 45 years and below.

This was the first time the CQC had inspected the practice. Data we reviewed showed that the practice was achieving results that were average or in some areas slightly above average with Sandwell and West Birmingham CCG in most areas.

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. The 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 October 2015. During our visit we:

- Spoke with a range of staff including the lead GP, a practice nurse, the practice manager and two reception staff. We spoke with a district nurse who was visiting the practice during the inspection. We also spoke with three patients who used the service.
- We reviewed comment cards where patients shared their views and experiences of the service.

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. We saw evidence that the practice had documented eight significant events for 2014-15. There was a significant events pro-forma available for relevant staff to complete and forward to the practice manager. The practice manager was the lead for dealing with significant events and they populated the template on an electronic system which was shared with the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. We saw examples where the practice had responded appropriately to incidents and learning was discussed in practice and clinical meetings. Minutes of meetings we looked at confirmed this.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements. Relevant policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.
- Most staff had worked at the practice for a long time and we saw that they knew their patients most of whom had also been registered at the practice for a long time. Staff members we spoke with demonstrated they understood their responsibilities in regards to safeguarding and had received training relevant to their role.
- A notice in the waiting room advised patients that the nurse or another staff member would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring (DBS) check. DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- We reviewed three personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through DBS checks.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and took part of the local infection control link worker scheme liaising with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. We saw that the lead in infection control attended yearly training and had conducted annual audits for example, handwashing.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). However, there was no evidence that the practice had a stock control system to record medicines that were kept in the surgery. When medicines were administered to patients the batch numbers were recorded for audit purposes.
- We saw that the practice carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments which was conducted by the practice manager. The practice manager had received online training as a fire marshal. The practice also carried out six monthly fire drills. We saw records to confirm that fire alarms and equipment were serviced regularly. The practice also had a variety of other risk assessments in

place to monitor safety of the premises such as control of substances hazardous to health. There was a legionella risk assessment conducted by the practice manager.

- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Reception staff members we spoke with told us that most worked part time and could cover colleagues in the event of unplanned absences. The practice manager we spoke with told us that they access to locum staff if needed.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which staff could use to alert colleagues to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. However, the practice did not have a nebuliser used for emergency treatment of many respiratory diseases.
- The practice did not have a defibrillator available on the premises. The practice attempted to undertake a risk assessment and contacted the ambulance service for response time in the event that a defibrillator was required. However, the practice received am email reply from the ambulance service that they were unable to provide a response time. The practice decided to purchase a defibrillator and confirmed this immediately after our inspection visit. There was oxygen available with adult and children's masks. The practice did not however have suction equipment to help remove secretions and mucus from airways.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, this was not robust. For example, the plan stated that the practice had an arrangement to use premises of another two nearby GP services but did not detail of the practices or how that would be achieved.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Evidence we looked at showed that the practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff members we spoke with told us how patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs and preferences. All comments cards we received and patients we spoke with were happy with the care they received from the practice.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines such as NICE on the computer system and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that these guidelines were followed through monthly peer reviews between the lead GP and the regular locum GP. Referrals to secondary care as well as emergency admissions were regularly monitored.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 85% of the total number of points available, with 6% exception reporting. The exception reporting was 3% below local and national averages. The QOF includes the concept of exception reporting to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.Data from 2014/15 showed;

- Performance for diabetes related indicators was 74%. This was 10% below the CCG and 14% below national average.
- The percentage of patients with hypertension having regular blood pressure tests was 77%. This was 11% below the CCG and 12% below the national average.
- Performance for mental health related indicators was above average. The practice achieved 100% of QOF points which was 10% above the CCG and 7% above the national average.
- The dementia diagnosis rate was 75% which was 5% below the CCG and 9% below the national average.

The practice had a significantly higher than the national average older patients registered with the practice and prevalence for some long term conditions such as hypertension was higher than local and national average. The practice manager informed us that one of the practice nurses retired and the practice was without 22 nursing hours per week for 6 months. Another nurse took on extra hours but overall the practice QOF achievement was down for 2014-2015. The practice employed a healthcare assistant (HCA) part time to help achieve their QOF targets and they joined the practice in April 2015. We saw that processes were in place to review patients with long term conditions. The practice manager told us that they were organising more review sessions with the practice nurse to ensure better QOF achievement.

Clinical audits demonstrated quality improvement. The practice had conducted an audit of prescribed antibiotics in November 2014 carried out by the medicines management team at the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The findings of the audit were that the practice conformed to guidelines 100% but alternative strategies were possible for 25% of patients was not explored. As a result an action plan was developed. The practice also carried out another medicines audit on cholesterol reducing medicines and appropriate action was taken from the findings.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. The practice induction template ensured role specific topics and training was covered and scheduled where possible.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, incident reporting, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. For example, staff had undertaken eLearning safeguarding as well as health and safety and manual handling. The practice manager had completed fire marshall training through e-learning.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.

The practice shared relevant information with other services in a timely way, for example when referring people to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated. We spoke with a district nurse who was visiting the practice during our inspection. They told us that the practice was very good at sharing information with them and they had a good working relationship.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The practice had a process to ask for, record and review consent decisions that were needed from patients. The practice undertook joint injections and we saw there were consent forms for patients to sign agreeing to joint injections.

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. We saw that the staff had attended training on MCA (2005) within the last two years.

We saw that the practice had developed shared care plans for many of the patients with long term and complex conditions. The practice involved patients to take part in developing their care plan so that they were involved in the decision making.

The practice offered interpreters to patients that did not speak English so that they could be made aware of their care and treatment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening in the preceding 5 years was at 84%, which was 4% above the CCG average and 2% above the national average. Patients were reminded to attend screening tests via letters and telephone.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to

Good

Are services effective?

(for example, treatment is effective)

under two year olds and five year olds were similar to local and national average. Data we looked at showed that flu vaccination rates for the over 65s were similar to local and national average. These services were delivered by the practice nurse with the support of the GP.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Most patients with long term conditions such as diabetes, asthma, cardiovascular disease (CVD) as well as Chronic Obstructive Pulmonary Disease (COPD) had received medication reviews. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were eight patients on the list and 62% of them had been reviewed so far this year. There were 11 patients registered with a mental health and 90% had received a review along with 83% of those registered with depression and 74% with dementia so far this year.

We observed that information on a range of topics was available in the practice waiting room. They included advice on smoking cessation, weight management, physical activity, health checks, diabetes, and cervical screening. Every four to six months the diabetes consultant carried out a joint clinic with the GP to better manage more complex patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people dignity and respect.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

The practice staff told us that the main challenge to maintaining confidentiality was the practice building, particularly the reception area. They told us that the practice had been purpose built a number of years earlier and did not take into consideration privacy at reception as the waiting area was very small. Staff were aware of this and tried to keep conversations as private as possible. Reception staff knew their patents well as most staff had worked in the practice for a long time. Similarly, most patients had been registered with the practice for a long time and when patients wanted to discuss sensitive issues or appeared distressed staff said they could offer them a private room to discuss their needs. Staff as well as the management team told us about their plans to merge with two other local practices and relocate to a new building nearby.

All of the 25 patient CQC comment cards we received were positive about the service experienced. All the patients we spoke with said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 84% and national average of 87%.
- 87% said the GP gave them enough time (CCG average 82%, national average 87%).
- 98% said they had confidence and trust in the last GP they saw (CCG average 80%, national average 85%)
- 89% said the last GP they spoke to was good at treating them with care and concern (CCG average 80, national average 85%).
- 97% said the last nurse they spoke to was good at treating them with care and concern (CCG average 87, national average 90%).
- 95% said they found the receptionists at the practice helpful (CCG average 63%, national average 73%)

Care planning and involvement in decisions about care and treatment

We spoke with three patients and received 25 completed comments cards. Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received were also positive and aligned with these views.

We reviewed results from the July 2015 national GP patient survey which showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 88% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 81%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

The practice's computer system alerted GPs if a patient was also a carer so that they could be more aware of their needs and signposted them to appropriate support groups. There was a practice register of all people who were carers and 1.9% of the practice list had been identified as carers.

Good

Are services caring?

There were various notice boards in the waiting room which displayed information about the various support groups and organisations patients could contact in the event of a bereavement. The practice also displayed posters in the reception area advertising the counselling service patients could access.

Staff told us that if families had suffered bereavement, the GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had arrangements for managing patients with chronic conditions such as asthma, diabetes and heart disease. Patients were invited for regular reviews of their health condition which were carried out by the GPs and trained nurses.

We saw minutes of meetings where patients with immediate or complex needs were discussed at regular clinical meetings. This ensured that all clinical staff involved in their care delivery were up-to-date and knew of any changes to their care needs. We saw evidence that the practice worked with a multidisciplinary team for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient's needs. We spoke with a health visitor on the day of the inspection and they told us that they worked well the practice.

The practice worked with another two surgeries locally to offer Saturday morning appointments. This was held at another surgery nearby and the GP from the three surgeries took turns to offer the service.

On days where the demand for services were greater, the GP offered more appointments. For example, the practice did not offer consultations with a GP from 1pm to 4pm where GPs carried out home visits as well as administration tasks. However, on days where the demand was greater (usually on Mondays) the GP offered appoints from 3pm. This was not formalised but we looked at the appointment system which confirmed that this was done regularly.

There were longer appointments available for people with a learning disability and home visits were available for older patients / patients who would benefit from these. Same day appointments were available for children and those with serious medical conditions.

There were facilities for people with physical disabilities as consultation rooms were available on the ground floor and we saw staff members assist a patient with physical disability. The practice did not have a hearing loop but staff told us that they had some patients who had difficulty with their hearing. Staff told us that they would manage communication with them by eye to eye contact and talking slowly to patients. For patients that did not speak English as a first language a translation service was also available.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday except Thursday when it closed at 1.30pm. Appointments were from 830am to 1pm every morning and 4pm to 6pm on Mondays, Tuesdays and Wednesdays. It closed at 1pm on Thursdays and on Fridays it offered consultations from 4.30pm to 6.30pm. We saw that when there was a need the GP would see patients from 3pm but this was not formally advertised. Extended hours surgeries were offered on Saturday mornings from 8.30am to 12.30pm. This was in partnership with two other local practices but we did not see this advertised for patients in the practice.

Pre-bookable appointments could be booked up to three months in advance and urgent appointments were also available for people that needed them. The practice was monitoring its failure to attend appoint (DNA) rate and found that it was higher for advanced appointments. It was considering reducing its advanced appointments but had planned to discuss this with the Patient Participation Group (PPG) before making a decision. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages. People told us on the day that they were able to get appointments when they needed them.

- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%.
- 95% patients said they could get through easily to the surgery by phone (CCG average 63%, national average 73%).
- 83% patients described their experience of making an appointment as good (CCG average64y%, national average 73%.
- 94% patients said they usually waited 15 minutes or less after their appointment time (CCG average 54%, national average 65%).

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

We saw that information was available to help patients understand the complaints system in the form of a complaints and comments leaflet that was available in the reception area for patients to take away.

The practice had received one verbal complaint for 2014-15. We saw that this had been addressed appropriately.

The practice also recorded patient grumbles which were unofficial complaints. We saw that they were dealt with where relevant.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.

The lead GP told us about the plan to merge with another two nearby surgeries and relocate to a purpose-built site very close to the current site. We saw plans that were in place and the lead GP told us that they were in the final consultation phase before they had the go ahead. Staff members we spoke with were aware of the developments and the benefits that would bring to patients.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was responsible for the day to day management of the practice and staff members we spoke with told us that the secretary assumed this responsibility when the practice manager was away on leave. The practice nurse was the lead for infection control and was supported by a policy. The lead GP was the lead for safeguarding. All the staff we spoke with were aware of the leads and who to approach for any issues. Staff members we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported.

There were arrangements for identifying, recording and managing most risks, issues and implementing mitigating actions. A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. We saw evidence clinical audits that were carried out demonstrating improvements in patient care. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate. We saw that this was displayed in the reception area encouraging further feedback from patients.

Leadership, openness and transparency

All staff we spoke with described the lead GP and management staff as being very approachable and had no concerns about any aspect of the practice. Most of the staff had been working at the practice for a long time and told us the practice was a great place to work and there were excellent working relationships within the team.

When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, truthful information and a verbal and written apology. We saw documented evidence where the practice had responded appropriately to the concern from a patient by inviting them to a meeting. The practice addresssed the concers and the patient had been left satisfied with the practice response.

There was a clear leadership structure in place and staff felt supported by management. Staff told us and we saw that the practice held regular team meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG group met six monthly and the practice also carried out patient surveys. For example, the practice had plans to merge with two other local surgeries and the PPG wrote to the Clinical Commissioning Group (CCG) in support of this. The PPG felt that this would benefit the patients. One of the patients we spoke with on the day of our inspection was part of the PPG and they also confirmed this. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice had also carried out a patient survey in December 2014. The practice displayed some of the finding with actions they were taking. This included feedback that waiting times were getting longer. The practice informed patients that they would increase the number of telephone

Are services well-led?

Good

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

consultations to reduce number of appointments thereby reducing waiting times. The practice also increased the number of emergency appointment slots in response to patient feedback.

Continuous improvement

There was a strong focus on continuous learning and improvement through audits and patient feedback. The practice recognised the need to offer improved service and outcomes for patients. To achieve this it recognised the need to merge with two other surgeries nearby so that more services could be offered. We were told that plans were in the final stages to achieve this.