Siddique and Agha

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

On 4 November we conducted an announced comprehensive inspection of Dr Siddique and Dr Agha. We found the practice had a clear strategy and a plan regarding how this was to be delivered. We found the practice treated patients with compassion, dignity and respect. Patients were involved in care and treatment decisions and were provided accessible information to help them understand the care available to them. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available on the day. The practice was well equipped to treat patients and meet their needs.

We saw outstanding practice in that;

- the practice recently secured funding to pilot weekend opening until March 2015. This was to reduce accident and emergency attendance by their patients. The practice is open Saturday 9am-1pm and Sunday 2pm-6pm with GP and a nurse practitioner assessing, prescribing and delivering treatments to patients. Early evaluation of the programme has shown good patient attendance and satisfaction and a reduction in admission numbers.

However, there were also areas of practice where the provider could improve and should;

- Ensure that completed clinical audit cycles are collated and learning shared within the practice.
- Revisit the role and responsibilities of the Patient Participation Group to ensure best use is being made of the resource.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learnt 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 with appropriate skills to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. staff had received appraisals and personal development plans and 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 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. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day and extended opening hours during the week and at weekends. 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.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity

Summary of findings

and regular meetings 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 a Patient Participation Group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice provided patients with a named GP, to oversee and coordinated their care. All patients aged 65 and over were offered flu vaccinations. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

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 longer appointments and home visits were available. All these patients had a named GP and structured annual reviews 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. Immunisation rates were relatively low for all standard childhood immunisations, acknowledged and being actively addressed by the practice due to cultural and language barriers. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

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 offered continuity of care. The practice was proactive in offering a full range of health promotion and screening at the weekend which reflected the needs for this age group.

Summary of findings

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 of patients living in vulnerable circumstances including adults with addictions and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and they were offered a follow-up.

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). 63.8% of people experiencing poor mental health had received an annual physical health check. 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 sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had an awareness of how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and reviewed 16 comment cards completed by people who attend the surgery ahead of our visit. All regarded the practice as good, very good or excellent and told us that the staff were polite and helpful and the surgery was safe clean and tidy.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that completed clinical audit cycles are collated and learning shared within the practice.
- Revisit the role and responsibilities of the Patient Participation Group to ensure best use is being made of the resource.

Outstanding practice

We saw outstanding practice.

The practice recently introduced weekend opening under March 2015. This was to reduce accident and emergency attendance by their patients. The practice is open Saturday 9am-1pm and Sunday 2pm-6pm with GP and a nurse practitioner assessing, prescribing and delivering interventions to patients. Early evaluation of the programme has shown good patient attendance and satisfaction and a reduction in admission numbers.

Siddique and Agha

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, CQC inspector and a practice manager.

Background to Siddique and Agha

Dr Siddique and Dr Agha are located in central Southend, Essex and provide services for approximately 9,500 patients living in the area. It is a socially and economically deprived area with a high proportion of their patient group who do not speak English as a first language.

The practice is situated in a shared purpose built medical centre and benefits from a number of specialist services operating from the building such as phlebotomy and Marie Stopes sexual health clinic. (Phlebotomy is the act of drawing or removing blood from the circulatory system through a cut (incision) or puncture in order to obtain a sample for analysis and diagnosis. Phlebotomy is also done as part of the patient's treatment for certain blood disorders).

There are two part time GP partners, one salaried GP, a practice nurse and health care assistant providing patients with access to both male and female clinicians.

The practice is part of a local federation of practices who collectively assist and share resources but operate as separate legal entities. The practice operates from a single location with no branch surgeries.

The practice holds a General Medical Services (GMS) contract with NHS England.

The practice does not currently have a practice website. Information is available to the public via NHS Choices. Dr Siddique and Dr Agha practice is open seven days a week. Late appointments were offered on Monday evenings until 8pm and the practice is participating in a local pilot scheme meaning they are open weekends in an attempt to reduce their hospital admissions. Since 11 October 2014 the practice has opened on Saturday 9am-1pm and Sunday 2pm-6pm with GP and a nurse practitioner assessing, prescribing and delivering treatments to patients. The pilot scheme will operate until March 2015 when it will be reviewed.

The practice does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed via the out of hours 111 service.

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.

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.

Detailed findings

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

Before inspecting, 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 4 November 2014. During our visit we spoke with a range of staff, GP, practice manager, practice nurse and reception staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Our data told us that the practice served a deprived population, especially amongst children and young people. There was higher than average number of people unemployed and with long standing health conditions and there were low vaccination rates for children and young people under five years of age.

The practice told us that they had a high turnover of patients due to serving some transient communities where English was not their first language. Their main patient languages after English were Polish, Spanish and West African, with many patients unable to read or write any English.

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 were detailed within the practice policies. For example, reported incidents, public health alerts, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Contact details of appropriate agencies were documented within the policies. For example, there was a policy on the notification of infectious diseases and guidance on the identification and escalation of concerns where a patient may have Ebola.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events; these were made available to us. We reviewed seven significant events, all had been investigated and responded to. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including, receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw that incident forms as well as policies and procedures were available on the practice intranet. Once a form was completed these were sent to the practice manager who showed us the system she used to oversee these were managed and monitored. We tracked two incidents and saw records were completed in a comprehensive and timely manner. However, the practice may wish to documented where things had gone well and share good practice.

National patient safety alerts were received by the practice manager and disseminated to either the clinical or administrative team. They were printed out and placed in a manual folder and an email circulation sent to relevant staff and discussed within the practice meetings. Staff we spoke with were able to give examples of recent alerts such as the Ebola identification and management of patients. They also told us about local patient alerts relating to the theft of patient prescriptions. These were discussed during one to ones with practice staff and administrative meetings where they revisited the security of their prescription documentation.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice regularly met with the health visitor on a monthly basis. They reviewed each child and young person to determine whether the risks were current and what was required to safeguard their needs. They jointly developed management strategies to ensure the wellbeing of the child such as inviting them to attend the surgery. The GPs contributed to child protection procedures and their multidisciplinary meetings were attended by a social worker.

All staff, both clinical and administrative, received child and young person safeguarding training. However, they had not all received training in safeguarding vulnerable adults. This was acknowledged by the practice manager who had arranged for staff to attend but this had presented challenges as the training was not available locally. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for individuals and specialist agencies were easily accessible.

The practice had monthly safeguarding meetings, attended by the GP, practice manager and health visitor. These were used to highlight families in which children may be at risk, including issues such as domestic violence, significant disability of a child, serious mental health concerns of carer and parental drug and alcohol addictions. This is in addition to safeguarding being a standing agenda items within the practice clinical and management meetings and raised with staff during their one to one supervision sessions. The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children. They had completed the necessary training to level three enabling them to fulfil this role. Clinical staff engaged in

children protection case conferences and reviews by submitting reports for consideration. All staff we spoke to were aware who the leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, the practice had highlighted where patients had addictions, mental vulnerabilities and may sell their medication.

GPs were using the required codes appropriately on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

A chaperone policy was in place and advertised on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by the reception staff who understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, SystmOne, which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were systems in place to ensure medicines were kept at the required temperatures and this was being followed by the practice staff.

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

We saw prescribing comparative data prepared by the Clinical Commissioning Group pharmacist. The data was specific and the GPs were aware of prescribing trends and had reviewed practices to ensure patients' medication was revised and appropriate. They had completed prescribing audits on antibiotics and medication vulnerable to abuse and had reduced their prescribing rates.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which followed national guidance. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Staff told us how they confirmed patient information and referred patients to the GP with an appointment or triage to authorise reissue of medication.

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

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Staff gave an example of how they supported a patient experiencing a mental health crisis to voluntary attend hospital to access emergency care and treatment.

Cleanliness & Infection Control

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

The practice nurse was the appointed infection control lead who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received infection control training via e-learning and this was refreshed every two years. Any specific risks were highlighted as and when the need arose and these were communicated through

Good

Are services safe?

staff one to ones and management meetings. We saw the infection prevention control lead had carried out audits for each of the last two years, the last was dated 26 October 2014. No actions or improvements were identified.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control measures. The practice nurse conducted a monthly stock control audit to ensure that staff had sufficient personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury dated January 2013 and subject to review in January 2015.

Hand hygiene techniques signage and hand sanitisers were available throughout communal areas. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice had not conducted regular testing of their water. However, they had made enquiries regarding commissioning the service to be undertaken immediately.

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 a schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, otoscope, ear syringe, spirometer. All portable electrical equipment was not routinely tested and did not display stickers indicating the last testing date. However, portable appliance testing to identify any potential fire risks had been scheduled for later in November 2014.

Staffing & Recruitment

We looked at five staff recruitment records. We found incomplete recruitment checks where references had not been obtained due to the candidate being known by a member of staff. None of the reception staff had received DBS checks but this was being considered by the practice due to them fulfilling chaperone responsibilities. Since the inspection the practice has confirmed that they have for DBS for all staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. We saw there was a rota system in place for all the different staffing groups to ensure they was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave where possible. For example the GP partners would often enhance their hours to cover for a colleague's leave, providing greater continuity of care as opposed to employing a locum doctor.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and an appointed lead.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff had all undertaken basic first aid training.

The practice also monitored repeat prescribing for people receiving medication for mental health needs.

We saw that the practice monitored repeat prescribing for people receiving medication for mental ill-health. They had also reduced their prescribing in response to a medicines report received from their Clinical Commissioning Group pharmacist.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Good

Are services safe?

external defibrillator was on order (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (the most serious type of allergic reaction. It can progress very quickly and may cause death without proper medical attention) and hypoglycaemia. This is a medical emergency that involves an abnormally diminished content of glucose in the blood. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan dated 10 January 2014 was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This was subject to review in January 2015. Each risk was described and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of who to contact in the event of an electricity supply failure. The practice manager was the appointed lead and held a copy of the plan off the premises to enable the coordination of such a response should they be unable to access the building.

We reviewed the fire safety policy dated 30 November 2012 and subject to review on 30 November 2014. This made reference to a fire risk assessment that had been undertaken. However, it was unable to be produced at the time of our inspection. We reviewed the fire alarm test record which detailed weekly checks of the systems and who had conducted them. The system was tested fully in March 2014 to ensure it was in working order and we saw evidence that the fire equipment had been checked and was in working order in February 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were responsible for their professional development and also maintaining knowledge of current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Staff told us that new guidelines were shared as they emerged and the potential implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

We found a GP had taken the lead for diabetes and had introduced a specific clinic in response to patient need for the service. The practice nurse supported this work by conducting foot examinations for diabetic patients. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We reviewed the local Clinical Commissioning Group report of the practice's performance for antibiotic prescribing which was comparable to similar practices. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed by their GP according to need. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and discussed during meetings to inform practice.

The practice showed us prescribing audits and two GP consultation audits relating to vulnerable patients. This included consideration of the content of the patient consultation. Although, there was limited data available to demonstrate monitoring and informing improving outcomes for people.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF is a national performance measurement tool. For example, we found the practice was performing well with QOF 2013-2014 and nearly achieved their all their objectives for delivering care.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs and were supported with appropriate action plans. We spoke with staff who confirmed they received twice monthly supervision and the practice was proactive in providing training and funding for relevant courses. The practice also benefitted from a GP being a trainer and providing the GP Registrar experience of the practice. GP registrars, are fully qualified and registered

Good

Are services effective?

(for example, treatment is effective)

doctors, They have passed out of medical school and completed their 2 years of preregistration in hospital and been admitted as fully registered doctors on to the GMC list.

Practice nurses received clinical supervision from the GPs and had defined duties they were expected to perform. They were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines and monitoring diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly team meetings to discuss the needs of complex patients where appropriate, such as those with end of life care needs or children on the at risk register. However, these were reviewed with partners involved in the assessment and delivery of the patient's care. Staff felt this system worked well and was more responsive and individual to the patient's immediate needs.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the Choose and Book system was available to patients. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice explained they had established a working agreement with the walk-in health service. Where their patients had attended the walk in centre they were invited to first attend the practice for an appointment The practice had found that many of their patients went to the walk-in facilities prior to requesting an appointment. This was despite availability, as patients had found it more convenient and did not mind waiting.

For emergency patients, the practice printed out relevant information with a covering letter for the patient to take with them to A&E. The practice also has signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Clinical staff had completed training in the Mental Capacity Act and provided examples of where this had been considered in care planning.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice maintained a register of vulnerable persons who required support to access/engage with health provision. The practice obtained patient consent to share information with family members or carers in accordance with the patient's wishes.

Care plans had been identified for persons requiring review and these were being developed. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent, such as where a patient agreed for information to be shared with a family member. This was recorded on a separate form and highlighted within the patient record.

The practice had not had an instance where restraint had been required. All reception staff had undergone conflict resolution and telephone communication course.

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The patient was required to see a GP regarding a medication review prior to the issuing of medications. The GP was also informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice also offered NHS Health well person checks and additional services such as weight reduction, smoking cessation and alcohol reduction.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and they were offered an annual physical health check. The practice actively tried to engage with patients through writing to them and working jointing with the community learning disabilities service.

The practice had also identified the smoking status of 92.3% of their patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. There was evidence these were having some success as 204 patients had stopped smoking in the last 12 months.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice monitored non-attendance of babies and children at vaccination clinics and worked closely with the community nursing team to enhance awareness and encourage attendance. The practice was aware of their low immunisations rates for children and had attributed this to their transient patient group and language/communication barriers with families who did not speak English as their first language. The practice had requested additional health educational material to be made available in various languages to help promote the benefits of child vaccinations to their diverse patient group.

Patients over 75 years were provided with a named GP and patients over 65 offered influenza immunisation and shingles vaccination for selected groups. The practice monitored unplanned hospital admissions to review the level of care being provided and those attending accident and emergency on multiple occasions were offered care plans. 90% of patients had been offered Cognition Testing, where appropriate. Cognitive tests, assess the capabilities of people and may include various forms of intelligence tests.

We found the practice offered patients with long term conditions a named GP and care plan. They monitored their conditions and provided them with information to help them self-manage and or prevent or identify deterioration in their condition. The practice confirmed that 66% of their patients with diabetes had received their annual foot check/ eye check. Patients were offered follow up appointments and referred to the single referral point to ensure patients received more integrated care.

We found there was good uptake rate for health checks for people of working age. 78% of patients requiring a cervical smear had received one and 90% of patients requiring blood pressure checks had had them. The practice manager was actively monitoring patient performance against national screening programmes since April 2014.

We found the practice maintained a register for people whose circumstances may make them vulnerable. They worked well with partner services through multidisciplinary forums and independently, whereby they coordinated personalised care. Reception staff maintained a record of support services and where appropriate staff signposted patients to them. The practice monitored attendance of patients for annual health check and follow up appointments but acknowledged further work needed to be done to enhance attendance rates.

We found patients experiencing poor mental health were offered and received an annual physical health check and 63.8% of people with severe mental health problems had attended for their health review. All were subject to care planning and where appropriate the practice had worked within a multidisciplinary team to coordinate care.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National Primary Care Research and Development Centre. 147 of the practice patients participated in the survey. The survey findings showed that 136 people rated the service as good, very good or excellent. The majority of responses stated the practice listened to patients and staff were polite and considerate. The majority thought the assessment of their medical condition was good or very good.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 16 completed cards all were overwhelmingly positive about the service they received. Patients said they felt the practice offered an excellent service, staff listened and politely explained everything to them and they felt they were supportive and caring. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed four patient questionnaires completed by patients attending the weekend opening service. All respondents had rated the service as good to excellent for all areas including ability to obtain an appointment, waiting times and quality of care provided during consultation.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice reception desk was shielded by glass partitions but information could still be overheard. Staff were aware of this and sensitive regarding the details they requested from people and the information they disclosed. We found that there were facilities available to have private conversations between patients and reception staff.

There was a notice displayed on the reception desk stating the practice's zero tolerance for abusive behaviour. Receptionists told us that their patient group could be challenging and staff could on occasions require a higher tolerance for addressing their patient needs. Staff told us they were supported by the practice manager who had previously spoken with patients regarding their conduct towards staff.

Care planning and involvement in decisions about care and treatment

The practice patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from their survey showed 95% of practice respondents said the GP was good at explaining their condition and involving them in their treatment.

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

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

Patient/carer support to cope emotionally with care and treatment

The practice told us how they identified patients with caring responsibilities and those requiring the assistance of carers. We were shown the written information available for carers to ensure they understood the various avenues of

Good

Are services caring?

support available to them. The practice's computer system alerted GPs if a patient was also a carer. Notices in the patient waiting room signposted people to a number of support groups and organisations.

Staff told us families who had suffered bereavement were contacted by their usual GP and/or sent a card. Where appropriate patients were signposted to bereavement services specific to their individual needs and circumstances.

Staff we spoke with were aware of the vulnerabilities of some of their patient groups such as those dependent on alcohol or substance misuse. Whilst not all had undergone training for vulnerable adults, this was scheduled and acknowledged by the practice as important. Nevertheless staff felt supported and able to recognise vulnerabilities and alert support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice recognised the diverse needs of their multicultural communities where English was not always their first language. The practice used a telephone interpreting service to aid communication with patients both during consultations and at reception. However the practice felt they were unable to be as responsive as they would wish to meet people's needs. For example they told us there was insufficient health information available in the various patient languages and sometimes staff did not have sufficient time to explain or answer patient's questions where they did not speak English.

The practice told us that they reviewed performance data to identify where they were failing to meet patient needs and to suggest potential gaps in service provision. For example, they had large diabetic population and had introduced GP-led diabetic clinics once a week, consisting of 20 minute appointments to enhance clinical care. This was supplemented by the practice nurse who undertook diabetic screening reviews such a foot care. They had also looked at the assessment and management of adult mental health patients. They had 63 patients on their register and they were provided with 20 minute appointments. We saw that their needs were reviewed every three to six months or as needed. We saw minutes of meetings where the introduction of specialist and individualised services were discussed.

There had been very little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. We found the practice provided home visits and longer appointments for older people and people with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes by a named GP and to those patients who required one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of comment card feedback. For example they had improved signage throughout the building to assist patients to find facilities.

The practice had four patients on an end of life care programme where they individually reviewed patient's needs. Although, they were not implementing the gold standards framework for end of life care, this was acknowledged by the practice but not considered necessary for the small patient numbers. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss care and support needs for patients and their families. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

The practice operated extended opening times including Saturday and Sunday and outside school and core working hours hours to assist working people, families, children and young people to access medical services.

Tackle inequity and promote equality

The practice had recognised the needs of different patient groups in the planning of its services. The practice had access to telephone translation services and GPs who spoke other languages. The practice also offered a range of clinics, asthma, child health and development, chronic obstructive pulmonary disease (COPD), obesity management clinic, primary care counselling services for anxiety/stress and bereavement. Recently they had introduced a diabetic clinic in response to their patients' clinical needs and had enhanced care provided to this patient group by appointing a GP to oversee their care.

The premises and services had been adapted to meet the needs of people with disabilities. There was ramp access to the building and an internal lift to the first floor. However, we witnessed patients with children's pushchairs and poor mobility experience difficulties with opening doors as they were not automatic. This had been acknowledged by the practice, they were considering the introduction of a door which opened automatically. Whilst the practice staff had not yet received equality and diversity training, they were aware of these training and development needs. They were awaiting information from the Clinical Commissioning Group (CCG) regarding course availability.

The practice told us they currently had 58 vulnerable adult patients identified by them or partner services such as health visitors and social services. These patients were flagged on the patient record system to be considered by clinicians when assessing and providing care. The practice told us how they registered people as temporary patients where appropriate to ensure they are able to access medical services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available on the day, in advance and for emergencies from 8am to 6.30pm, four out of five weekdays. Late appointments were offered on Monday evenings until 8pm. The practice was also participating in a local pilot scheme, and was open weekends in an attempt to reduce their hospital admissions. Since 11 October 2014 the practice had opened on Saturday 9am-1pm and Sunday 2pm-6pm with GP and a nurse practitioner assessing, prescribing and delivering interventions to patients. Early evaluation conducted by the practice showed patients valued the service and their hospital admissions had declined. The pilot scheme will conclude on 31 March 2015.

The practice did not have their own website and the information available on NHS choices website was not reflective of current services provided. For example, it did not detail the availability of the Saturday and Sunday clinics. The practice manager stated they were in the process of developing their own website which would be informed from patient feedback such as the 60% of their patients surveyed who have internet access.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. The practice's extended opening hours on Monday until 8pm and Saturday and Sunday was considered by the practice to be exceptionally useful to patients with work commitments.

The practice was situated on the ground and first floors of the building with the majority of services for patients on the first floor. Lift access was provided to the first floor. Patients with mobility scoters were asked to leave their vehicles outside the premises. Currently the service did not have any patients who required mobility support internally.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures dated 11 January 2014 were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person for handling all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of a practice complaints procedure leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint and the leaflet included details of how to appeal, if they were dissatisfied with the outcome. None of the patients spoken with had ever needed to make a complaint about the practice, but were also unaware of how to raise a concern despite the presence of a complaints leaflet within the communal waiting areas. However, the complaints leaflet was not available in languages other than English.

We looked at three complaints received in the last seventeen months. We found all had been investigated and were addressed in a timely and appropriate manner. The practice had accepted responsibility and apologised where appropriate whilst identifying lessons learnt and proposing means of resolving the issue to mitigate the risk of similar occurrences in the future.

Whilst the practice reviewed complaints they did not conduct any themes or analysis. However, where they had received comments from patients both formally and informally they had amended systems and processes to reflect patient needs. For example, many patients commented on the poor signage within the building for patients and those attending one of the other services provided at the premises such as the Marie Claire early termination service or phlebotomy. This resulted in clear signage now displayed throughout the practice and a reduction in patient complaints and requests for staff to provide directions.

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. We reviewed the practice's statement of purpose detailing their aims and objectives such as extending their accessibility to patients. They had identified funding streams to improve service provision for their patients and were committed to evaluations and the evolvement of the practice.

There was no formal documented five year business plan but staff were aware and the management were clear about what and how they intended to continue to develop and expand the service to meet their patient needs. For example, they had recently introduced electronic prescribing and staff were aware of the importance of this serve to both patients and the clinical team.

We spoke with clinical and administrative staff and all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff and held monthly meetings. We looked at minutes from the last meetings and found that performance, quality and risks had been discussed. For example prescribing patterns and improving services through the introduction of electronic prescribing service. The latter should assist in more timely and efficient processing of prescriptions.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The Quality and Outcomes Framework **(**QOF**)** is the annual reward and incentive programme detailing GP practice achievement results. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse and health care assistant both received clinical supervision and were supported to access and attend training such as time to learn sessions provided locally by NHS England.

Leadership, openness and transparency

We found a strong clinical team with clear understanding amongst them of their clinical strengths and how to complement the work of one another. This was achieved under the strong and clear leadership of the practice manager. The manager understood and co-ordinated all areas of clinical practices to ensure an accessible and sustainable services for patients. We found the manager to be open and receptive to feedback and challenge from staff and external parties. Staff told us that felt valued, well supported and had confidence in the manager should they have any questions or concerns. We spoke with members of staff and they were all clear about their own roles and responsibilities and were held accountable. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

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

The practice conducted their own survey of patients in 2014 and was completed by 147 patients. The outcome was reviewed in November 2014 and had a supporting action plan in place. However, the practice may wish to note that tasks had not been assigned to individuals and no review date set. 76% of the patients who completed the survey thought the reception staff were helpful and 93% of them would recommend the practice to someone who had just moved to the area.

The practice recognised and supported the involvement and consultation with patients. They had a patient participation group (PPG) consisting of 15-20 members. Documentation had been provided to the group explaining their role and purpose, highlighting four main areas of work, obtaining feedback from patients, health promotion, information and acting as a representative group. We found the PPG was not representative of their patient group and when we spoke to the chair of the PPG they accepted that they had not sought to actively engage with patients to understand and represent their views. The practice manager showed us the analysis of the last patient survey. However, the PPG reported no involvement with the

Are services well-led?

Good

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

designing, administering or evaluation of the questionnaires. There were clear opportunities to improve the relationship between the practice and PPG to the benefit of both parties.

The practice regularly gathered feedback from staff through regular supervision sessions, informally through daily contact and during one to one supervision.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through protected time for training and mentoring. We looked at staff files and saw that regular supervisions and appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training in addition to time to learn.