Pak Health Centre - R Bhatti

Quality Report

38 Alum Rock Road
Saltly
Birmingham
B8 1JA
Tel: 0121 327 3926
Website: www.pakhealthcentre.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We completed a comprehensive inspection at Pak Health Centre - R Bhatti on 27 March 2015. The overall rating for the practice is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains.

Our key findings were as follows:

- Systems were in place to ensure that all staff had access to relevant national patient safety alerts. Staff worked together as a team to ensure they provided safe, co-ordinated patient care.
- Infection prevention and control systems were well managed and staff had received appropriate training.
- Staff were friendly, caring and respected patient confidentiality. Patients we spoke with said that all staff were compassionate, listened to what they had to say and treated them with respect. We observed that staff at the reception desk maintained patient's confidentiality.
- There was a register of all vulnerable patients who were reviewed regularly. Patients we spoke with told us they were satisfied with the care they received and their medicines were regularly reviewed. Information and feedback from patients was used to deliver service improvement.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This was evident when speaking with staff and patients during our inspection. There was a clear leadership structure with named staff in lead roles.

In addition the provider should:

- Commence full cycle clinical audits to demonstrate improvements in patient care and treatments are an on-going process.

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 was rated good for providing safe services. There were systems in place to address incidents and to protect children and adults and other vulnerable patients from risks of harm. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. They took action to learn from incidents and made appropriate safeguarding referrals when required. Appropriate checks had been carried out before staff commenced working at the practice. Patients we spoke with told us they felt relaxed and comfortable with practice staff during their visits to the practice.

Are services effective?

Good

The practice was rated good for providing effective services. Clinicians were up to date with both the National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines which were influencing improved outcomes for patients. Patients' needs were assessed and care was planned appropriately to meet their needs. There were effective arrangements to identify, review and monitor patients with long term conditions. Multidisciplinary working was evident to ensure patient needs were appropriately met. Staff appraisals were carried out which identified their personal development needs.

Are services caring?

Good

The practice was rated as good for providing caring services. Feedback from discussions with patients during the inspection and the comment cards we received provided positive comments about the standards of care they received. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them. We observed that staff interacted with patients in a polite and helpful way and they greeted patients in a friendly manner.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Staff made use of information to understand and respond to the needs of their local population. The practice was accessible to patients with limited mobility and other needs. Practice staff engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. There was evidence that staff listened and responded to suggestions made by patients and the Patient Participation Group (PPG). These resulted

Summary of findings

in adjustments to meet the needs of patients. There was a complaints procedure that staff followed. Staff responded appropriately and promptly to any complaints received and brought them to resolution.

Are services well-led?

Good

The practice was rated as good for providing well lead services. All staff had designated lead roles for delivery of an effective service. There was a clear set of values which were understood by staff and evident in their behaviours. There was a defined leadership structure in place and staff communicated well at all levels. A range of staff meetings were held and where possible improvements were discussed and agreed. Governance and performance management arrangements had been proactively reviewed. High standards of service provision were promoted and owned by all practice staff.

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 was rated as good for providing safe services. Patients aged over the age of 75 years had been informed of their named and accountable GP. All older patients had annual health checks and where necessary, care, treatment and support arrangements were implemented. The practice offered proactive, personalised care to meet the needs of older people and had a range of enhanced services. For example, employment of an advanced nurse practitioner who saw patients who had diabetes. The practice was responsive to the needs of older people, including offering rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice was rated as good for providing effective services. Data showed that patient outcomes were generally at or near the national average. The practice took into account clinical guidelines such as National Institute for Health and Care Excellence (NICE) when providing care. Patients' needs were assessed and care was planned appropriately to meet their needs. There were effective arrangements to identify, review and monitor patients with long term conditions. Staff received training that was appropriate to their roles to maintain their knowledge and skills. Staff appraisals were carried out which identified their personal development needs. Health promotion and prevention was provided within the practice. Multidisciplinary working was evident to ensure patient needs were appropriately met.

Families, children and young people

Good

The practice was rated as good for care of families, children and young people. Practice staff had good working relationships with health and social care professionals to provide support for this population group. Requests for young children's appointments were booked for the same day. Systems were in place for identifying and following up children who were at risk of harm. Childhood immunisation was provided at the practice. Cervical screening was offered to female patients. Midwives held ante natal clinics were held at another practice. Post natal clinics were held at the practice and staff had good links with health visitors.

Working age people (including those recently retired and students)

Good

The practice was rated good for care provided to working age people (including those recently retired and students).The practice

Summary of findings

offered extended opening hours to assist this patient group in accessing the practice. Extended appointments were available from 6:30pm until 9pm each Monday. For those patients who were unable to get an appointment on the day they could arrive by 10:30am any weekday and wait to be seen without an appointment. Patients were also able to request telephone consultations. The practice was proactive in offering on-line services for making appointments and ordering repeat prescriptions.

People whose circumstances may make them vulnerable

Good

The practice was 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. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients and had sign posted vulnerable patients to various support groups and other organisations. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. Patients within this population group were offered regular health checks and GPs organised extra community assistance for them.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated good for people experiencing poor mental health (including people with dementia). Care was proactive and tailored to patients' individual needs and circumstances including their physical health needs. Annual health checks were offered to patients with significant mental health illnesses. Doctors had the necessary skills to treat or refer patients with poor mental health. Practice GPs were able to make referrals to the Mental Health Trust. All staff worked within the boundaries of the Mental Capacity Act 2005 and had appropriate skills for supporting patients with dementia.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection who varied in age and clinical needs. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given clear explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received. We were told it was easy to obtain repeat prescriptions. Patients said they did not have a problem in obtaining an appointment but did experience difficulty in getting through to the practice by telephone.

We collected 26 Care Quality Commission comment cards left in the surgery prior to the inspection. All comments made about care were positive. The comments reflected that staff were helpful and how professional they were. Two comment cards were less positive, however there were no themes to these responses.

The Patient Participation Group (PPG) had carried out an annual survey. PPG's are an effective way for patients and surgeries to work together to improve services and promote quality care. We met with four members, including the chair person on the day of the inspection. They commented positively about how they had influenced changes and the good standards of care they received. A copy of the patient survey report dated 21 March 2014 had been given to each member of the PPG. The PPG members we spoke with told us they discussed recommended improvements from the report during their meetings and how these would be approached. PPG members told us that when they visited the practice as a patient they noted any concerns and reported them during their meetings held every four months with senor staff. For example, the floor covering of the waiting area had been replaced last year and paintwork refreshed.

The National Patient Survey results dated 2013-2014 informed us that the results were average or above the national average for the practice:

- 60.4% of respondents would recommend the practice,
- 58.6% reported satisfaction in getting through to the practice by telephone,
- 74.8% were satisfied with the opening times,
- 68.8% had good or very good experience for making an appointment,
- 72.5% reported their overall experience was good or very good.

These results were rated as being average nationally.

Areas for improvement

Action the service SHOULD take to improve

- Commence full cycle clinical audits to demonstrate improvements in patient care and treatments are an on-going process.

Pak Health Centre - R Bhatti

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team also included a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

Background to Pak Health Centre - R Bhatti

Pak Health Centre – R Bhatti serves approximately 4700 patients. The practice delivers primary medical care for patients in a densely populated and deprived area. 94% of the patients registered at the practice were Asian. There was a growing population of Eastern Europeans where interpreters may be required. The perinatal mortality rate is amongst the highest in the country. There was a lower that average rate of diagnosed chronic obstructive pulmonary disease (COPD) and a higher rate of patients who suffer with diabetes.

At the time of our inspection there were a mixture of one male and two female GPs. During periods when cover was needed the same locum GP had been used for two years. Other clinical staff consisted of an advanced nurse practitioner who worked one six hour session each week and a full time practice nurse. The practice employed a management consultant on a part time basis to assist with developing policies and procedures and finances. The practice manager had recently been promoted and they were supported by five receptionists who worked varying hours.

The practice offered a wide range of services including chronic disease management, diabetes, cervical smears, contraception, injections and vaccinations. External professionals heal sessions every two weeks for mental health patients and drug abuse.

The practice had opted out of providing out-of-hours services to their own patients. This was provided by the Badger services. Patients were advised to use the local walk-in centre when the practice was closed or to contact NHS 111 if it was an emergency. This information was available in the waiting area, in the patient leaflet, via the practice telephone and on the website.

There were no previous performance issues or concerns raised with the Care Quality Commission about this practice prior to our inspection.

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
- 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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 27 March 2015. During our inspection we spoke with a range of staff including three GPs, the practice nurse, the practice manager and two receptionists. We also spoke with 10 patients who used the service and received 26 comment cards from patients. We observed how patients were being cared for and staff interactions with them. We looked at relevant documentation in relation to patient care and treatment.

Good

Are services safe?

Our findings

Safe Track Record

We spoke with 10 patients during the inspection. None of them told us they had concerns about their safety and told us they were comfortable when in the presence of staff.

The practice used a range of information to identify risks in relation to patient safety. For example, reported incidents, 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 of incidents or accidents.

We reviewed safety records, incident reports and minutes of monthly meetings where these were discussed. A member of clinical staff we spoke with gave an example of a recent significant event. They had found a number of incidents where patients required medicine reviews that had not initially been picked up. Actions were taken to ensure these took place before the prescriptions were issues.

There was a system in place for regular reviews of complaints received by the practice. We saw that individual complaints were discussed at clinical staff meetings and later analysed by the practice manager to check if there were any trends. The recordings indicated there were no trends.

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. We saw that significant events were recorded, analysed and discussed at staff meetings with an aim to take account of any lessons to be learned. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. For example, we saw that following a mix up of patient's records when sending out patient information. A system was put in place for a senior member of staff to check all records that were shared with a third party.

We saw that the practice had recorded five significant events during the last 12 months which had been reviewed and categorised to identify any trends or themes.

Reliable safety systems and processes including safeguarding

The practice had a lead GP appointed for safeguarding vulnerable adults and children. All clinical staff had had been trained to the appropriate level in safeguarding to enable them to fulfil their roles. Practice training records made available to us showed that all non-clinical staff had received relevant role specific training on safeguarding. All staff we spoke with were aware of who the lead was and who to speak with if they had concern about patient safety. We saw that there were policies regarding the protection of children and vulnerable adults.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and were aware that they should contact the relevant agencies in or out of hours. Contact details of investigation agencies were easily accessible to all staff.

Quarterly safeguarding meetings were held. Community staff were invited to attend such as the family support worker, community matron and the district manager for child case review. The minutes of the latest meeting we reviewed included the agreed action that was taken regarding a child who was considered to be at risk of harm. The practice manager told us about the outcome and the actions that external staff had taken to support the family.

We saw that a chaperone policy was in place. Chaperone duties were usually undertaken by the practice nurse. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw chaperone notices were displayed in all clinical rooms and the waiting area of the practice. Some patients we spoke with were aware that they could have chaperone if needed. The practice nurse was able to demonstrate they carried out this task appropriately. Non-clinical staff we spoke with told us they did not chaperone patients.

Medicines Management

Patients were able to order repeat prescriptions on line, by fax, by email, in person or via their local pharmacy. Patients we spoke with said they were happy with the system. There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

Good

Are services safe?

We found that vaccines were stored within the recommended safe temperature range in a lockable fridge. The practice nurse told us they rotated the vaccines weekly to ensure that they remained in date and safe for administration. Temperature checks were taken and recorded each day. Medicines were kept within locked cupboards.

GPs told us they did not routinely carry medicines in their bags when they carried out home visits. They told us that depending on the information provided by patients when they rang to request a home visit GPs would collect any medicines they thought they may need from the practice.

Cleanliness & Infection Control

Environmental cleaning of the whole building was undertaken by an external contractor and monitored by the acting practice manager. We saw that cleaning schedules for all areas of the practice were in place.

All staff had undertaken on line training in control and prevention of infection.

We were told that the practice manager was the lead for infection control and prevention. Annual audits were carried out and the last audit was dated 8 August 2014. The results were positive and the report included some actions that were needed. For example, staff needed to de-clutter clinical rooms. We saw that this had been dealt with appropriately. The clinical rooms we visited were neat, tidy and well organised.

We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed with the date of use to enable staff to monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste.

Legionella risk assessments had been completed annually to ensure that any risks to patients from potential contaminated water was identified and acted on. Legionnaires' disease is a form of bacteria which can live in all types of water.

Equipment

The clinical staff we spoke with told us they had sufficient equipment to enable them to carry out their duties including, assessments and treatments. The practice manager told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw documentary evidence of this. We saw evidence of calibration of relevant medical equipment had been carried out.

Staffing & Recruitment

Newly recruited staff completed a probationary period and were assessed before they were given a permanent contract.

Staffing levels were based on numbers and experience of each staff member and how the practice operated over the years. Consideration had also been given to the needs for the patient groups and their need to access the service. Staffing was monitored and reviewed as required.

We were told that reception and administration staff covered for each other by working extra shifts to ensure continuity during periods of annual leave. When the practice nurse took leave they did not organise cover. Patient's appointments were arranged around the practice nurse's leave. When GPs were not available a locum GP was used during those times to provide cover. The practice had used the same locum for two years.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults.

We saw that relevant checks were completed to ensure clinical staff were up to date with their professional registration, for example nurses were registered with the Nursing and Midwifery Council (NMC). The NMC was set up to protect the public by ensuring that nurses and midwives provide high standards of care to their patients and clients. The practice also kept a record to demonstrate that GPs were registered on the performers list. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England.

Good

Are services safe?

Monitoring Safety & Responding to Risk

Risk assessments were in place which included areas of health and safety associated with the general environment. Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks.

There was a health and safety policy in place and staff knew where to access it.

There were some arrangements to deal with foreseeable emergencies. We saw that the staff at the practice had received training in medical emergencies such as basic life support. The practice had a defibrillator which is a piece of life saving equipment that can be used in the event of a medical emergency. Oxygen was also on hand for treating patients. All of the staff we asked knew the location of the emergency medicines and equipment.

Arrangements to deal with emergencies and major incidents

We saw the business continuity plan. The document detailed the actions that should be taken in the event of a major failure and contact details of emergency service who could provide assistance. Copies of the document were held off site by the practice manager and the GPs. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond. It included the contact details of services that may be able to help at short notice.

Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency. A fire safety risk assessment was in place and had been reviewed annually to ensure it was still relevant. We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

The patient leaflet and a recorded message on the telephone gave information about how to access urgent medical treatment when the practice was closed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with were able to describe how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE) standards. NICE provides national guidance and advice to improve health and social care. To keep up to date with guidance the GPs told us that they attended meetings and appropriate training courses and read relevant literature.

We were told that the computer system included 'flags' to alert staff if a patient was also a carer of a patient and for those patients on the practice's palliative care register. This information was useful to ensure that staff were able to provide the level of support required and signpost patients to appropriate services if required.

An advanced nurse practitioner was employed to hold a weekly six hour session at the practice. Their main role was to carry out regular reviews and health checks of patients who were diagnosed with diabetes.

The minutes of the monthly practice meetings told us that hospital admissions were regularly discussed to identify where changes could be made that may prevent admissions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with clinical staff 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

The GPs had not completed clinical audits to ensure that appropriate and up to date care and treatments were being given to patients. The GPs acknowledged that this work needed to be commenced as a matter of priority.

Performance information on patient outcomes was available to staff and the public, which included monitoring reports on the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. QOF targets were reviewed regularly and we saw evidence of satisfactory QOF achievement.

GPs were supported by a pharmacist who visited the practice regularly. The pharmacist provided advice about medicines that GPs prescribed for patients. We were not shown recordings that confirmed clinical audits concerning medicines had been carried out.

We saw that there was a low prevalence for diagnosing chronic obstructive pulmonary disease (COPD). We spoke with a GP and the practice nurse about this. We were told that the practice nurse had been booked to attend a training course on COPD that afterwards would enable them to diagnose these patients.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. The practice nurse we spoke with told us they had opportunities for continuing professional development to enhance their role.

GPs had completed their yearly continuing professional development requirements and they had either 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 the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff had annual appraisals that identified any learning needs from which action plans were documented. We saw that the practice nurses' appraisals were carried out by clinical staff. This was so that that their practices could be assessed and discussed.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, palliative (end of life) care teams and district nursing services to meet patients' needs.

Community nurses supported patients who were palliative care. A GP who had received training regarding palliative care was the designated lead for this aspect of care. We saw that records and care plans of patients who received palliative care were comprehensive. Regular meetings were held with the community matron and community nurses

Good

Are services effective?

(for example, treatment is effective)

present. We were told that McMillan nurses also attended these meetings. Unplanned hospital admissions were discussed and actions agreed that may prevent future admissions. This promoted a partnership for ensuring patients received appropriate and integral care.

There were systems in place to ensure that the results of tests and investigations from out of hours and hospitals were reviewed and actioned.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information Sharing

We saw evidence that the practice held multi-disciplinary meetings to discuss the needs of complex patients for example those with end of life care needs to ensure important information was shared. We saw joint working arrangements were also in place with the palliative care team quarterly.

The GP's we spoke with told us they had good working relationships with community services, such as district nurses.

There was a system in place to ensure the out of hours service had access to up-to-date treatment plans of patients who were receiving specialist support or palliative care.

For patients who had attended an out of hours service or following discharge from hospital we were told that the information provided to them was reviewed on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or physiotherapist.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Clinicians were aware of the requirements within the Mental Capacity Act 2005. This was used for adults who lacked ability to make informed decisions. Staff gave examples of how a patient's best interests were taken into account when a patient did not have capacity to make decisions about their treatment.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Childrens and Families Act 2014 and were able to describe how they implemented it in their practice. GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

We saw that all new patients were offered a health check. New patients who had received prescribed medicines from previous clinicians were given an appointment with a GP to review the medicine dosage to ensure it was appropriate.

Patients who were due for health reviews were sent a reminder to make an appointment. Patients were asked about their social factors, such as occupation and lifestyles. These ensured doctors were aware of the wider context of their health needs.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw some health and welfare information displayed in the waiting area. For example, breast screening and shingles vaccinations for patients aged 70 years. Letters were sent to patients to encourage them to undergo screening such as, breast screening.

A range of tests were offered by practice staff including spirometry (breathing test) blood pressure monitoring and cervical smears to regularly monitor their health status. The practice nurse told us they gave advice to patients about healthy lifestyles when they visited the practice.

The practice leaflet that was available to all patients provided information about the services available. For example, chronic disease management, women's health and child health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested for private discussions. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that clinical room doors were closed during consultations and that conversations taking place in these rooms could not be easily overheard. We observed staff knocking on doors and waiting to be called into the room before entering. We saw that clinical room doors were closed during consultations and that conversations taking place in those rooms could not be easily overheard.

We spoke with 10 patients and collected 26 comment cards during the inspection. Our discussions with patients on the day of the inspection and feedback from comment cards told us patients felt that staff were caring and their privacy and dignity was respected.

Patients confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff.

The National Patient Survey results informed us that the results were average or above average for the practice:

- 60.4% of respondents would recommend the practice,
- 58.6% reported satisfaction in getting through to the practice by telephone,
- 74.8% were satisfied with the opening times,
- 68.8% had good or very good experience for making an appointment,
- 72.5% reported their overall experience was good or very good.

These results were rated as being average nationally.

Care planning and involvement in decisions about care and treatment

We found that patient care was an absolute priority and was embraced by the whole practice team. Each GP had a lead role for ensuring then population needs were being met.

Clinical staff supported patients to understand their care and treatment options including the risks and benefits to enable them to make informed decisions. Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. They told us they were able to make informed decisions about their care and felt in control.

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.

The practice nurse we spoke with told us they explained treatments and tests to patients before carrying out any procedure. They told us that patients were kept informed of what was going to happen at each step so that they knew what to expect.

Patients we spoke with confirmed they had been given advice and choices about where they could be referred to assist them in making decisions for secondary assessment and care.

Patient/carer support to cope emotionally with care and treatment

The respective GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. There were also bereavement counselling services available and a service called 'Healthy Minds' that GPs could make referrals to.

A GP told us that due to the culture of the population group they rarely agreed to provision of extra services because they relied on family support.

We saw information was on display in the waiting area for patients to pick up and take away with them. They informed patients of various support groups and how to contact them.

Practice staff held a carers register of people who provided care to others to enable staff to suggest ways of supporting them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and hypertension. There were nurse led services such as diabetes. There were immunisation clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated. We were shown statistics for the number of patients between the ages of 65 years and 85+ years and saw that 90% had received their annual health checks.

The practice had a mental health register for patients who had had a health check. Patients who had a learning disability were also registered and clinical staff made efforts to carry out health checks and provide support services for them. There was a palliative care register and quarterly multidisciplinary meetings were held to discuss patient and their families care and support needs.

There was a mixture of male and female GPs available at the practice which gave patients the option of receiving gender specific care and treatment.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs attended CCG meetings where actions were agreed to implement service improvements and manage delivery challenges to its population. For example, clinical staff maintained regular liaison with a pharmacist to ensure patients received appropriately prescribed medicines.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example they had requested new floor covering in the reception and waiting area and this was actioned.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had made arrangements for meeting their needs.

A GP told us that 94% of the population were Asian. Also 70% of all appointments were conducted in the patient's first language which was not English. Staff spoke Urdu, Pashtu, Punjabi, Hindi and Bengali to assist patients in understanding their health and care needs. We were told of the increasing Eastern European population. Staff told us that translation services were available for patients who did not speak English as a first language. This service could be arranged to take place either by telephone or face to face. Staff had also arranged for a sign interpreter service for a patient who was unable to hear.

The premises were accessible to patients who had restricted mobility. There was a toilet for people who had restricted mobility. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

The practice was located within a purpose built building and was designed to be accessible for wheelchairs and pushchairs. The waiting could accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was a fully equipped toilet for patients who had restricted mobility.

Appointments were available from 9am until 12:30pm and from 4:30pm until 6:30pm each weekday except Wednesday afternoons. Extended hours were available until 9pm every Monday. Any patient who arrived by 10:30am who did not have an appointment would be seen by a GP at the end of the clinic session. We were told that patients were happy to wait until a GP was free to see them. Reception staff told us they never turn a patient away who was requesting an appointment. Children and emergency requests were seen on the same day.

With the exception of one patient we spoke with they told us they were able to book an appointment when they needed to. One comment card informed us they had problems in booking appointments at the appropriate times.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were able to book and order repeat prescriptions online from their own homes. This was useful for working age patients as well as those who had difficulty with their mobility.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hour's service was provided by an external service contracted by the CCG. Details of the out of hour's provider were available on the practice leaflet and in in the practice.

Listening and learning from concerns & complaints

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

There was a practice leaflet that informed patients of how to make a complaint and what they could expect. It included the contact details of NHS England and the local ombudsman if the complainant was not satisfied with the outcome of the investigation.

We saw that the practice had received two complaints during the previous 12 months. They had dealt with them appropriately and written responses had been sent to complainants. Lessons learned had been documented to prevent recurrences. For example, a patient was not happy with the medicines that had been prescribed for them. The GP had offered the patient a referral for further assessment. The complaint was discussed during a practice meeting and recordings made to confirm the efforts that had been made to resolve the issue.

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 development plan in place dated 2014-15. It stated that suggestions for improvements would be shared with the local clinical Commissioning Group (CCG) to gain their opinions. The practice objective was to provide skilled care with focus on holistic care, mental health and preventative health care. To aid this programme we saw evidence that GPs had sought external support for patients with long term conditions.

There was an aim to develop specialties such as paediatrics (children) and diabetes education. We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at recordings from meetings held by practice staff that demonstrated the vision and values were still current.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively.

There were specific identified lead roles for areas such as safeguarding and palliative (end of life) care. Responsibilities were shared among GPs, the practice nurse and the practice manager.

We saw that regular practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff were encouraged to attend these meetings. Recordings were made of the meetings and any actions that arose from these meetings were clearly set out and reviewed to ensure required changes were made. Staff told us they could make suggestions for improvements and that they would be listened to by senior staff.

Leadership, openness and transparency

Staff we spoke with told us they were all clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that practice staff held a range of regular meetings. They included clinical meetings, multidisciplinary meetings for long term conditions and practice meetings. The minutes told us that all aspects of the running of the practice were discussed as well as ways of taking corrective actions to meet patient's needs. For example, unplanned admissions were regularly discussed to ensure they were appropriate and if actions could be taken to prevent future admissions.

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

We found there were strong, positive relationships between practice staff and the Patient Participation Group (PPG). We looked at the minutes from the latest PPG meeting; we were told PPG members they were held every four months. A GP attended these meetings. The minutes of the last meeting told us that there was a good informing process from senior practice staff to keep everyone updated. They also included progress against areas where improvements had been made such as, the practice remaining open each Wednesday so that patients could access the receptionists.

During our inspection we spoke with four PPG members. They were positive about their relationship with senior staff and their responses when suggestions for improvements were made. One PPG member told us if necessary they could make urgent appointments with the senior partner to discuss areas of concern about the practice that had arisen. All PPG members told us they had influenced positive changes to the operations of the practice. For example, re-painting of the ground floor of the practice and improved lighting in the waiting area.

We were shown a copy of the annual patient survey dated 21 March 2014. Questions were around putting patients at ease, having enough time for consultations, listening and explaining to patients, and how treatment had been arranged. Results indicated that patients were satisfied with the standards of care they received. A copy of the results of the survey had been shared with PPG members and discussions held on areas where improvements had been made.

Staff we spoke with told us they felt well supported and were able to express their views about the practice.

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring.

Are services well-led?

Good

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

GP's held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt.

The practice had completed reviews of significant events and other incidents and shared them with staff through meetings to ensure the practice improved outcomes for patients. There had been five recorded during the previous 12 months. For example, a request for prescription of a medicine for a patient from another health professional had been received by email. All staff were advised to protect patient confidentiality by not accepting requests from unsecured emails. They were reminded to use the NHS email system and for third parties to do the same.