Dr Fatin Karam

Quality Report

2A Penvalley Crescent
Liverpool
L6 3BY
Tel: 0151 285 4415
Website: www.fairfieldmc.nhs.uk

Date of inspection visit: 8 June 2016
Date of publication: 27/07/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Fatin Karam known locally as Fairfield Medical Centre on 8 June 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Risks to patients were assessed and well managed, apart from those relating to the premises.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Feedback from patients on the day of the inspection about their care was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Data showed that outcomes for patients at this practice were similar to outcomes for patients locally and nationally.
- Information about services and how to complain was available for patients.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- There was a clear leadership and staff structure and staff understood their roles and responsibilities.
- The practice provided a range of enhanced services to meet the needs of the local population.

The areas where the provider should make improvement are:

Summary of findings

- Induction records should be completed for all new staff.
- A risk assessment for the need to have oxygen and an automated defibrillator on site in an emergency should be undertaken. According to current external guidance and national standards this equipment should be in place in all practices.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. There was a system in place for reporting and recording significant events. We found that where unintended or unexpected safety incidents had occurred, patients received reasonable support information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice had systems, processes and practices in place to keep people safe and safeguarded from abuse. There were infection control policies and procedures in place, staff were aware of their responsibilities in relation to these. There were safe systems in place for the management of medicines. The practice did not have a defibrillator or oxygen equipment on the premises for use in a clinical or medical emergency.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams with good engagement with community services. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. The practice worked in conjunction with other practices in the locality to improve outcomes for patients. Staff worked on a multidisciplinary basis to meet the needs of people receiving end of life care. Clinical audits were carried out to drive improvement in outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients we spoke with during the inspection confirmed this. Data from the National GP Patient Survey showed patients rated the practice around average and higher than others for several aspects of care. For example, 93% of respondents said the last GP they saw or spoke to was good at treating them with care and concern (compared to a national average of 85%). Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff knew 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 and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had a Patient Participation Group (PPG) which at the time of inspection had lapsed. Staff had received inductions and regular performance reviews.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had named GPs for all patients and also specifically for those over the age of 75 years. The practice offered a variety of health checks for older people specifically memory screening and osteoporosis risk assessments.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff were appropriately trained and had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority. They worked with outside agencies to ensure patients were supported and received a high quality of care within the community. These included district nurses, heart failure team and a neighbourhood team made up of both health and social care staff. Care plans were in place for at risk patients which permitted information sharing with the wider community team. Initial appointments were made with the GP followed by regular review by the nurses at the practice. Patients with long term conditions were provided with literature and disease specific information to enable self-management of conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Weekly mother and baby clinics for baby and postnatal checks were provided. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were good for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. For babies and young children up to the age of five an appointment to attend was provided at the end of the morning to avoid long waits.

Summary of findings

Appointments were also available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered a telephone consultation service every day as well as pre-bookable appointments for morning and afternoon surgeries. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice also used the Electronic Prescribing System, increasing convenience for patients who might work during the day.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It offered longer appointments for people with a learning disability and for those whose first language was not English. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advanced care planning for patients with dementia and had a mental health register of patients. The practice had told patients experiencing poor mental health

Summary of findings

about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The results from the National GP Patient Survey results published in January 2016 showed the practice was performing in line with local and national averages. There were 402 survey forms distributed and 96 were returned, this is a completion rate of 23.9% and representative of almost 2% of the practice patient list.

The survey results were at or above the local CCG and national averages for patient access. For example;

- 97% said the GP was good at listening to them compared to the CCG average of 90% and national average of 88%.
- 93% said the GP gave them enough time compared to the CCG average of 89% and national average of 86%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 86% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 87% said the nurse gave them enough time compared to the CCG average of 93% and national average of 91%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and national average of 97%.
- 95% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 81%.
- 78% said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The National GP Patient Survey results showed that patient's satisfaction with access to care and treatment was generally above or close to local and national averages. For example:

- 32% of respondents with a preferred GP usually get to see or speak to that GP compared to the national average of 36%.
- 77% of patients said they could get through easily to the surgery by phone compared to the national average of 73%.
- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 89% patients described their experience of making an appointment as good compared to the national average of 78%.
- 91% of patients found the receptionists at this surgery helpful compared to the CCG average of 88% and national average of 86%.

We received 18 comment cards and spoke to five patients. Positive comments were made about how friendly, caring and supported all staff were and how they had been treated with dignity and compassion. All patients said that they were happy with the care, staff were caring and respectful.

Areas for improvement

Action the service SHOULD take to improve

- Induction records should be completed for all new staff.

Summary of findings

- A risk assessment for the need to have oxygen and an automated defibrillator on site in an emergency should be undertaken. According to current external guidance and national standards this equipment should be in place in all practices.

Dr Fatin Karam

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 and practice manager specialist adviser.

Background to Dr Fatin Karam

Dr Fatin Karam (also known as Fairfield Medical Centre) is responsible for providing primary care services to approximately 5090 patients. The practice is a long established GP practice working in the centre of Liverpool in a very deprived area of the city with a high population of non-English speaking patients. The practice has a General Medical Services (GMS) contract and offers a range of enhanced services such as flu and shingles vaccinations, minor surgery and timely diagnosis of dementia. The number of patients with a long standing health condition is about average when compared to other practices nationally.

The staff team includes one lead GP partner with support from two GPs partners from neighbouring practices. The practice also has two practice nurses, a practice manager, pharmacy staff and administration and reception staff.

The practice is open from 8am to 6.30pm Monday to Friday. Extended hours were available until 7.30pm on a Wednesday evening. Home visits and telephone consultations were available for patients who required them, including housebound patients and older patients. There are also arrangements to ensure patients receive urgent medical assistance out of hours when the practice is closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 June 2016. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

Detailed findings

- 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. A meeting took place on an annual basis to review all of the incidents to identify trends and themes. We were told that all incidents were discussed with relevant staff at monthly practice meetings but no records were made of this. We reviewed the incident reports that had been made and these showed all incidents had been reviewed and investigations and action had been taken to ensure a similar incident did not occur again.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. They had also been trained to an appropriate level and we found that following recent safeguarding training for vulnerable adults they had reviewed the practice policy and made changes to increase staff awareness and ensure patient safety. The policies for children outlined who to contact for further guidance if staff had concerns about a patient's welfare. We saw that alerts were put onto the electronic patient records system to identify if a child or adult was at risk. Staff we spoke with understood their responsibilities and all had received training relevant to their role.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and arrangements were in place for them to receive a Disclosure and Barring Service check (DBS check), DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The lead GP was the infection control clinical who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken, we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams and their in house pharmacy staff. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed five personnel files and found satisfactory information relating to, for example, proof of identification, qualifications and registration with the appropriate professional body. New staff had recently been recruited and while they confirmed that had been interviewed and had received a thorough induction no records had been kept of this. There was some missing information such as indemnity insurance for clinical staff and vaccination status but this was sent to us following the inspection.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

There were a number of procedures in place for monitoring and managing risks to patient and staff safety. For example;

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. Portable electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was

working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice did not own the premises it was on lease from an external contractor. We saw the contractor had responsibility for ensuring fire safety checks such as emergency lighting and alarm testing was carried out weekly. We found that such checks had not been completed since March 2016 and despite contact from the practice at the time of inspection this had not been achieved. Information relating to this, fire safety in general and a fire risk assessment was sent to CQC after our inspection.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents in part only. We found that;

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice did not have a defibrillator or oxygen equipment on the premises. We were therefore not assured the practice could take appropriate action if there was a clinical or medical emergency.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant, current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

The provider had produced a range of assessment tools to ensure that the care and treatment provided to people who had long term conditions was reviewed and planned in line with best practice guidance. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening their clinical record.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available, the CCG average being 95% and the national average was 94%. The practice performance for some national and clinical targets was either in line or slightly higher than national and local results. For example data from QOF results for 2014/15 showed;

- Performance for diabetes assessment and care was generally higher than the national average. For example the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 99% compared to 88% nationally. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 88% compared to 78% nationally.
- Performance for mental health assessment and care was higher than other practices. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (April 2014 – March 2015) was higher than the national averages, at 95% compared to 89% nationally. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in their record, in the preceding 12 months (April 2014 – March 2015) was 92% compared to 88% nationally. Information provided by the local Clinical Commissioning Group (CCG) indicated that the practice had achieved the majority of indicators for mental health at the time of inspection.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 92% compared to 89% nationally.

We looked at the processes in place for clinical audit. Clinical audit is a way to find out if the care and treatment being provided is in line with best practice and it enables providers to know if the service is doing well and where they could make improvements. The aim is to promote improvements to the quality of outcomes for patients. For example, knowing that performance for diabetes related indicators were not in line with national averages the practice employed a pharmacist to work with them to review all patients. This included conducting a baseline audit, checking all patient medicines, making changes as required and undertaking further tests and onward referral of patients for specialist help and advice.

Staff worked with other health and social care services to meet patients' needs. Multi-disciplinary meetings were held to review the care and treatment provided to people receiving end of life care and those with complex needs. Clinical staff spoken with told us that frequent liaison occurred outside these meetings with health and social care professionals in accordance with the needs of patients. The GPs and nurses had key roles in monitoring and improving outcomes for patients. These roles included the management of long term conditions, palliative care, cancer, alcohol and drug misuse, dementia, safeguarding and promoting the health care needs of patients with a

Good

Are services effective?

(for example, treatment is effective)

learning disability and those with poor mental health. The clinical staff we spoke with told us they kept their training up to date in their specialist areas. This meant that they were able to focus on specific conditions and provide patients with regular support based on up to date information.

Effective staffing

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

- Staff told us they felt appropriately trained and experienced to meet the roles and responsibilities of their work. Staff had been provided with training in core topics including: safeguarding, fire procedures, and basic life support and information governance awareness. Staff had also been provided with role-specific training. For example, staff that provided care and treatment to patients with long-term conditions had been provided with training in relevant topics such as diabetes, podiatry and spirometry. Other role specific training included training in topics such as administering vaccinations and taking samples for the cervical screening programme.
- We heard from newly appointed staff that they had undergone a thorough induction programme but no induction records were kept for this. We saw they had completed training following appointment that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Clinical staff held lead roles in a range of areas including; diabetes, chronic obstructive pulmonary disease (COPD), asthma, peripheral arterial disease, heart failure, sexual health, contraception and mental health. Staff across the practice knew who the clinical leads were and patients could be allocated clinicians based on their clinical presentation or known health conditions.
- Clinical staff were kept up to date with relevant training, accreditation and revalidation. There was a system in place for annual appraisal of staff. Appraisals provide staff with the opportunity to review/evaluate their performance and plan for their training and professional development. Staff attended a range of internal and external meetings. GP attended meetings with the CCG. Practice nurses attended local practice nurse forums. The practice was closed for one half day per month to allow for 'protected learning time' which enabled staff to attend meetings and undertake training and professional development opportunities.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. This included assessments, care plans, medical records and test results. We saw good examples of care plans for patients with complex and end of life care needs. The practice used the 'Gold Standard Framework' (this is a systematic evidence based approach to improving the support and palliative care of patients nearing the end of their life) to ensure patients received appropriate care.Evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated were also shown to us.

The practice took part in an enhanced service to support patients to avoid an unplanned admission to hospital. This was a particular challenge for the practice population which included refugees and asylum seekers who had recently entered the country and did not understand how to access health services out of GP hours. The practice produced a patient letter to inform them of the different community and primary health services they could access rather than attending A&E for primary health care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had received training for this. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice offered national screening programmes, vaccination programmes, children's immunisations, long term condition reviews and bowel screening. We found that health promotion information was available in the

Good

Are services effective?

(for example, treatment is effective)

reception area and on the website. The practice had links with health promotion services and recommended these to patients, for example, smoking cessation, alcohol services, weight loss programmes and exercise services. New patients registering with the practice completed a health questionnaire and were offered a health assessment with the nurse or health care assistant. A GP or nurse appointment was provided to new patients with complex health needs, those taking multiple medications or with long term conditions.

The practice monitored how it performed in relation to health promotion. It used the information from the QOF and other sources to identify where improvements were needed and to take action. QOF information for the period of April 2014 to March 2015 showed outcomes relating to health promotion and ill health prevention initiatives for the practice were comparable to or above other practices nationally. Childhood immunisation rates for vaccinations given for the period of April 2014 to March 2015 were generally comparable or above the CCG averages (where this comparative data was available).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations to promote privacy. Patients who were distressed or who wanted to talk to reception staff in private were offered a private room to discuss their needs.

We received 18 comment cards and spoke to five patients. All of the comments made showed that patients felt a very good service was provided and that clinical and reception staff were dedicated, professional and listened to their concerns. Patients indicated that their privacy and dignity were generally well promoted.

Data from the National GP Patient Survey January 2016 (data collected from January-March 2015 and July-September 2015) showed that patient' responses about whether they were treated with respect and in a compassionate manner by clinical and reception staff were higher or about average when compared to local and national averages for example:

- 97% said the GP was good at listening to them compared to the CCG average of 90% and national average of 88%.
- 93% said the GP gave them enough time compared to the CCG average of 89% and national average of 86%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 86% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 87% said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and national average of 97%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt health issues were discussed with them, they felt listened to and involved in decision making about the care and treatment they received.

Data from the National GP Patient Survey January 2016 showed patients responses to questions about their involvement in planning and making decisions about their care and treatment and results were generally in line with local and national averages. For example:

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 86%.
- 88% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 89%.
- 78% said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Information about how patients could access a number of support groups and organisations was available at the practice. Information about health conditions and support was also available at the practice and on the practice's website. The practice's computer system alerted GPs if a patient was also a carer. Carers were offered longer appointments if required.

Good

Are services caring?

Patients receiving end of life care were signposted to support services. Staff sent bereavement cards to carers following bereavement and they signposted them to bereavement support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice worked to ensure unplanned admissions to hospital were prevented through identifying patients who were at risk and developing care plans with them to prevent an unplanned admission. The practice ensured that services were planned and delivered to take into account the needs of different patient groups and we found examples of good practice as follows:

- For patients who may be too ill, elderly or housebound, a home visit was arranged. To provide further choice the practice offered pre-bookable appointments, morning, afternoon and telephone surgeries.
- For patients who cannot get into the surgery during in-hours an extended hour's surgery on Wednesday was provided.
- Patients with chronic diseases, language barriers, or who would prefer a longer time to discuss their health concerns with the team, were accommodated by longer appointments.
- The practice was participating in the Avoiding Unplanned Admission enhanced service as proposed by NHSE. This involved co-ordinated working between GPs, practice nurses, district and mental health nurses and the wider primary care health team as well as social services and secondary care input to focus on the needs of the vulnerable elderly patients.
- The practice had recently invested in a Pharmacist who was providing input in managing poly pharmacy and medicine optimisation especially in the older and diabetic patient population.
- The practice referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives. It was reported that this service was beneficial in reducing access to the out of hours and accident and emergency services.
- Translation services were available for patients and patient information was available in different languages

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday. Extended hours were available until 7.30pm on a Wednesday evening. Appointments were from 8.30am to 6.30pm daily. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice also had an open access system each morning and patients spoke positively to us about this.

Results from the National GP Patient Survey showed that patient's satisfaction with how they could access care and treatments were mixed. For example;

- 89% of patients were satisfied with the practice's opening hours (national average 78%).
- 77% patients said they could get through easily to the surgery by phone (national average 73%).
- 83% say the last appointment they got was convenient (CCG average 92%, national average 91%)
- 67% were able to get an appointment to see or speak to someone the last time they tried (national average 86%).
- 77% describe their experience of making an appointment as good (CCG average 75%, national average 73%).

We received 18 comment cards and spoke to five patients. Patients said that they were able to get an appointment when one was needed, they were able to get through to the practice by phone easily and were happy with the opening hours.

We heard how the practice proactively sought to improve access to healthcare for their diverse patient population. We saw this in the way staff handled phone calls and face to face conversations with patients with language needs. Telephone and face to face interpreters were used frequently at the practice and if needed longer appointments were available with the GP. We heard that to support patients who had recently entered the country a patient letter had been sent to them. This explained the different primary care services available to them and it encouraged patients to access services at the practice rather than their regular attendance at A&E. Staff members we spoke with had a good understanding of the different cultural needs of the practice patient population.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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. Information about how to make a complaint was available for patients to refer to in the waiting room, in the patient information booklet and on the practice website. This included details of who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a record of written and verbal complaints. We reviewed a sample received within the last 12 months. Records showed they had been investigated, patients informed of the outcome and action had been taken to improve practice where appropriate. A log of complaints was maintained which allowed for patterns and trends to be easily identified. The records showed openness and transparency with dealing with the complaints.

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 and all staff were fully committed to the vision of providing high quality, friendly a personal health care to all patients of the practice. Their ethos was to treat all patients with courtesy, respect and dignity at all times irrespective of ethnic origin, religious and cultural beliefs, gender, sexual orientation, social class, disability or age. We heard how this had been achieved from patients we spoke with during the inspection and in our observations made during the inspection.

Staff understood the part they played in delivering this vision, and had a good understanding of how their work contributed to the overall performance of the practice.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. The GPs used evidence based guidance in their clinical work with patients. The GPs had a clear understanding of the performance of the practice. The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance.

The GPs had been supported to meet their professional development needs for revalidation (GPs are appraised annually and every five years they undergo a process called revalidation whereby their licence to practice is renewed. This allows them to continue to practise and remain on the National Performers List held by NHS England).

The practice had policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Policies were up to date and had regular review dates. The practice held monthly practice meetings during which time governance and risk management issues were discussed. Risks that had been identified were discussed and actions taken. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership and culture

The GPs in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care.

They were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. We spoke with staff with different roles and they were clear about the lines of accountability and leadership. They spoke of good visible leadership and full access to the senior GP and practice manager. Staff told us they enjoyed working at the practice and they felt valued in their roles. Staff felt supported, motivated and reported being treated fairly and compassionately. They reported an open and 'no-blame' culture where they felt safe to report incidents and mistakes. The practice had a strong team who worked together in the best interest of the patient. All staff were aware of the practice Whistleblowing Policy and they were sufficiently confident to use this should the need arise.

The provider was aware of and complied with the requirements of the Duty of Candour. The management team encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and how to learn from these.

When there were unexpected or unintended safety incidents, the practice gave affected people reasonable support, truthful information and a verbal and written apology. They kept written records of verbal interactions as well as written correspondence.

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

The practice actively encouraged and valued feedback from patients. They encouraged patient feedback with patient questionnaires and surveys and they had a Patient Participation Group (PPG) which was found at the time of the inspection to have lapsed. On the day of the visit however we spoke with one PPG who told us the practice manager and GPs were responsive to suggestions she made and her involvement in the work of the practice. The practice had recently added to their website information about how members of the public could become a member of the group.

Feedback from staff was gathered on an informal basis and also at newly developed practice meetings held monthly. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They reported an open culture within the

Are services well-led?

Good

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

practice and said they had the opportunity to raise any issues at team meetings, they felt confident in doing so and felt supported. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had recently invested in a Pharmacist who was providing input in managing poly pharmacy and medicine optimisation especially in the older and diabetic patient population.

We found that mandatory training was undertaken and monitored to ensure staff were equipped with the knowledge and skills needed for their specific individual roles. Staff were supervised until they were able to work independently but written records of this were not kept. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at a number of staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.