ISSA Medical Centre - Dr Z H Patel

Quality Report

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Date of inspection visit: 5 August 2016
Date of publication: 19/09/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at ISSA Medical Centre on 5 August 2016. Overall the practice is rated as good.

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

- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events, although actions taken as a result of these events were not systematically reviewed.
- Risks to patients were assessed and well managed although references for new practice staff were not always sought, as per the practice's recruitment policy.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Protocols and policies for managing blank prescription forms were in place, however staff using loose prescription forms did not log them in and out and prescriptions were left in prescription printers overnight.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good policies and procedures although these were not easily available to staff and there was no structured programme for their review.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients we spoke with praised the practice environment.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

- The practice had recognised the needs of Muslim patient families and had been the first practice in the area to work in partnership with the coroner and the Muslim burial committee. The practice had facilitated timely access to these services particularly out of working hours. This led to families being able to satisfy the needs of their religion and bury their relatives within appropriate timescales. This service was then rolled out to other practices in the area.

The areas where the provider should make improvement are:

- The practice should consider that systems are put in place to check that actions identified by significant event reports are effective.
- The practice should minimise the risks that may be associated with the security of blank prescription forms.
- The practice should follow its recruitment policy and obtain references for all new staff employed.
- The practice should make policies and procedures easily available to all staff and review them systematically.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice. However, actions implemented were not formally reviewed.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Protocols and policies for managing blank prescription forms were in place and new supplies of prescriptions were securely stored. However, although the use of prescription pads was monitored, staff using loose prescription forms did not log them in and out and prescriptions were left in prescription printers overnight.
- The practice had good recruitment policies, however, practice policy had not always been followed for new staff prior to their employment. The practice had relied on the references obtained by the charitable organisation through which the staff had been employed. There was no evidence of references obtained for five of the six staff files that we viewed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- One of the practice GPs had a special interest in dermatology and saw patients with skin problems at the practice in order to reduce referrals to other services.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice had invested in an electronic service that provided specialist interpretation of patient electrocardiograph test results (ECG, a test to check the heart's rhythm and electrical activity). This service had been rolled out to other practices in the locality.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for most aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- The practice had produced a number of its own leaflets that were relevant to the practice population such as the use of antibiotics, information on joint injections, patient use of steroids and keeping children and young people safe.
- We saw staff treated patients with kindness and respect and maintained patient and information confidentiality.
- The practice invited local and national charities into the practice every other month to raise awareness of their work amongst the practice population and to help to raise funds.

Are services responsive to people's needs?

Good

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. The practice had recognised the needs of Muslim patient families and had been the first practice in the area to work in partnership with the coroner and the Muslim burial committee. The practice had arranged for contact details to be shared so that timely access to these services was assured, particularly out of working hours. Details had also been shared with out of hours services.
- 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

Summary of findings

participation group. They extended telephone access to the practice and started Saturday morning surgeries. They also invested in a new telephone system and extended the patient car parking area.

- The practice provided a clinic for patients who were taking anti-coagulant medication to prevent blood clotting. Patients were able to attend this clinic every week to monitor blood-clotting levels instead of having to travel a considerable distance for the same service.
- In order to get better control for diabetic patients, the practice employed a GP with a special interest in diabetes to provide a weekly clinic for diabetic patients at the practice. This GP also mentored and trained practice clinical staff.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients we spoke to praised the practice environment.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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. Staff were sometimes unsure as to where to access practice policies and we were told that they would shortly be available on the practice intranet. The practice had no plan to ensure that policies and procedures were regularly reviewed.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels. In-house clinical education events had been scheduled for every month until December 2017.
- The practice had taken part in local pilot projects for example, receiving x-ray results electronically.
- The practice was a training practice and provided support and mentorship to medical students and GP trainees at different stages of their learning.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- A local organisation visited the practice every month to give social care advice.
- There was a dedicated practice emergency number that was available when needed and was shared with care homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was lower than the national average for some indicators and higher for others. For example, the percentage of patients who had their blood sugar levels well-controlled was 65% compared to the national average of 78% but the percentage of patients with blood pressure readings within recommended levels was 90% compared to the national average of 78%.
- The practice had employed a GP with a special interest in diabetes. This GP held a clinic once a week at the practice to treat diabetic patients and we saw evidence that diabetic control for these patients was improved.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice had trained a health care assistant to check the register of patients every month who needed regular clinical monitoring because of the high risk medications that they were prescribed.

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- One of the practice GPs had a special interest in dermatology and saw patients with skin problems in order to reduce referrals to other services.
- The practice had screened patients for possible memory loss at influenza clinics one year and for possible heart problems the previous year.
- The practice provided a clinic at the practice for patients who were taking anti-coagulant medication to prevent blood clotting. Patients were able to attend this clinic every week to monitor blood-clotting levels instead of having to travel a considerable distance for the same service.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- 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 relatively high 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.
- The practice's uptake for the cervical screening programme was 43%, which was lower than the clinical commissioning group (CCG) average of 69% and the national average of 82%. Because of low figures, the practice had participated in a local cancer screening initiative project. A member of the local black and minority ethnic (BME) network attended the practice and contacted patients who had failed to attend for cervical screening. The BME member made 239 telephone calls and as a result, 53 patients then attended for a cervical smear.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice sent a congratulations card to all new mothers together with confirmation of a postnatal appointment at the surgery.
- The practice engaged with children by running competitions and by displaying pictures drawn by children in its waiting room. There was a large game painted on the waiting room floor.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice opened on a Saturday morning between 8am and 12noon for those patients who were unable to attend during normal working hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people who circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with complex needs and with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- A nurse from the local hospice attended the practice weekly to support patients and their families and carers.
- The practice had close links with local rehabilitation services for patients who had been experiencing difficulties with drug and alcohol problems and provided health checks for those patients.
- 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.
- The practice had recognised the needs of Muslim patient families and had been the first practice in the area to work in partnership with the coroner and the Muslim burial committee. The practice enabled timely communication for bereaved families, a practice which was adopted by other neighbouring surgeries.

Summary of findings

- The practice ordered and displayed special information posters during Ramadan in reception.
- GPs at the practice visited a local care home every week in order to provide more personal, timely care for complex patients with spinal injuries and to reduce unplanned admissions to hospital.
- The practice gave its dedicated emergency number to the local accident and emergency service and gave them permission to contact the practice directly in order to reduce the number of contacts made with the service by a patient.
- The practice GPs gave their mobile numbers to all patients and their families in an end of life situation and for those with complex needs.
- The practice had piloted a virtual multidisciplinary team project whereby the practice made a regular daily telephone call with other members of community services to discuss vulnerable patients with complex needs who were at risk of hospital admission. Services then made arrangements wherever possible to manage these patients in their own homes.

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).

- 100% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the last 12 months, which is better than the national average of 84%.
- 93% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line or below local and national averages. 417 survey forms were distributed and 91were returned. This represented 0.8% of the practice's patient list.

- 66% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 68% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 74% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 78% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received. Patients commented that they always received excellent care from helpful, professional staff. Patients said that they were impressed by the level of care provided and that the service could not be improved.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. One patient told us that there were not enough words to say how good the practice was.

Areas for improvement

Action the service SHOULD take to improve

- The practice should consider that systems are put in place to check that actions identified by significant event reports are effective.
- The practice should minimise the risks that may be associated with the security of blank prescription forms.
- The practice should follow its recruitment policy and obtain references for all new staff employed.
- The practice should make policies and procedures easily available to all staff and review them systematically.

Outstanding practice

The practice had recognised the needs of Muslim patient families and had been the first practice in the area to work in partnership with the coroner and the Muslim burial committee. The practice had facilitated timely access to these services particularly out of working hours. This led to families being able to satisfy the needs of their religion and bury their relatives within appropriate timescales. This service was then rolled out to other practices in the area

ISSA Medical Centre - Dr Z H Patel

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to ISSA Medical Centre - Dr Z H Patel

ISSA Medical Centre is housed in a purpose-built two storey building in the Deepdale area of Preston at 73 St Gregory Road, Preston. PR1 6YA. The building was constructed in 2009 and currently houses two separate GP surgeries, a pharmacy and various other patient health care services. The practice provides level access for patients to the building with automated entry doors and is adapted to assist people with mobility problems. The majority of patient services are located on the ground floor of the building with some consulting and treatment rooms situated on the first floor. Access to first floor rooms is by using a lift or stairs. There is onsite parking and the practice is close to public transport. The practice provides services to 11,288 patients.

The practice is part of the NHS Greater Preston Clinical Commissioning Group (CCG) and services are provided under a General Medical Services Contract (GMS).

There are two GP partners, one male and one female, and four salaried GPs, three male and one female. The practice also employs a sessional GP who is a GP with a special interest in diabetes to run a weekly clinic for diabetic patients. The practice clinical staff consist of an advanced nurse practitioner, two practice nurses, two health care assistants and a clinical pharmacist. The non-clinical team consists of a practice manager, a deputy practice manager and 14 administrative and reception staff who support the practice.

The practice is open between 8.30am and 6pm every weekday except Thursday when it closes at 1pm and on Saturday between 8am and 12noon. Telephone lines to the practice open at 8am on weekdays and close at 6.30pm except on Thursdays when they close at 1pm. When the practice is closed, patients are able to access out of hours services offered locally by the provider Preston Primary Care Limited by telephoning 111.

The practice population is heavily weighted towards patients aged less than 40 years of age. There are 17% of patients aged between five and 14 years of age compared to the national figure of 11%, and 11% aged under five years of age compared to the national average of 6%. Only 8% of patients are aged 65 years of age or over compared to the local average of 16% and the national average of 17%. Approximately 65% to 70% of the practice list is Asian or Asian British at any one time.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Both male and female life expectancy is less than the local and national average, 79 years for females compared to 82 years nationally and 76 years for males compared to 79 years nationally.

The practice caters for a smaller proportion of patients experiencing a long-standing health condition than

average practices (48% compared to the national average of 54%), however, the onset of illness is earlier for some chronic conditions such as diabetes. The proportion of patients who are in paid work or full time education is lower (60%) than the CCG and national average of 62% and unemployment figures are higher, 7% compared to the CCG and national average of 5%.

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. 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 5 August 2016. During our visit we:

- Spoke with a range of staff including two GPs, two practice nurses, one health care assistant, six members of the practice administration team.
- Spoke with five patients who used the service and two members of the practice patient participation group (PPG).
- Observed how staff interacted with patients and talked with carers and 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:

- 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.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had 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. The incident recording form supported the recording of notifiable incidents under the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) The practice had a duty of candour policy.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Staff involved in the significant event met to discuss the incident and agreed actions that needed to be taken. Staff not involved in the incidents were informed of significant events at practice meetings. However, the practice did not review outcomes of the actions taken.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, when an error led to the practice telephone line being unavailable to patients after a bank holiday, the practice reviewed its policy to ensure that a mobile telephone was always available and also re-trained staff in the use of telephone procedures when the practice was closed.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. 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. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level 3.
- A notice in the waiting room and notices in all of the consulting and treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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 practice nurse was the infection control clinical lead 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. We saw evidence that infection control audits were undertaken, however, the latest audit was incomplete. We saw evidence that the practice completed the audit on the day following inspection.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice had a protocol to ensure certain identified high risk medications could only be issued on repeat by GPs. The practice pharmacist carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor the use of prescription pads. However, there was no system in place to log the use of loose, computer prescription forms and forms were left in prescription printers overnight and when rooms were not in use. The practice told us on the day of inspection that they would put

processes in place to log and secure these forms immediately. The practice pharmacist had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines against a patient specific direction from a prescriber.

- We reviewed six personnel files and found that the majority of appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, we found that contrary to the practice recruitment policy, there were only references for one staff member present in the files and no evidence that the practice had requested references for other staff. The practice told us that they had relied on the references obtained by the charitable organisation through which the staff had been employed.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the staff room which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All 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).
- 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. The practice identified staff that were able to cover for unexpected staff absence in advance and recorded this on the rotas in case of need.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All clinical staff received annual basic life support training and there were emergency medicines available in the treatment room. However, basic life support training for administrative staff was only done every three years and the practice had not carried out any risk assessments for these staff. The practice told us that they would increase the number of training sessions booked for the next update training so that all staff could be included.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- 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 and 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 patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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 97.2% of the total number of points available. Exception reporting figures for the practice were a little higher than the clinical commissioning group (CCG) and national averages (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice exception reporting figure overall was 9.4% compared to the CCG average of 8.8% and the national average of 9.2%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was lower than the national average for some indicators and higher for others. For example, the percentage of patients who had their blood sugar levels well-controlled was 65% compared to the national average of 78% but the percentage of patients with blood pressure readings within recommended levels was 90% compared to the national average of 78%.
- Performance for mental health related indicators was better than the national average. For example, 93% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the national average of 88% and 100% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the national average of 84%.

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits completed in the last two years, four of these were completed audits where the improvements made were implemented and monitored. The practice pharmacist also carried out medication audits to monitor practice prescribing. The practice had noted that antibiotic prescribing was high and had audited the prescribing of antibiotics for children. Clinicians were educated in the appropriate use of these medications and a re-audit was completed. As a result, appropriate prescribing increased from 36% to 54%.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included safer prescribing of nonsteroidal anti-inflammatory drugs for patients with certain chronic illnesses.

Information about patients' outcomes was used to make improvements such as more appropriate prescribing of medications to prevent blood clotting.

Patient electrocardiograph results (ECG, a test to check the heart's rhythm and electrical activity) were sent electronically for specialist interpretation which was relayed back to the practice. This service had since been adopted by other practices in the locality.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The GP with a special interest in diabetes provided in-house training and mentoring for clinical

Good

Are services effective?

(for example, treatment is effective)

staff. Staff working in reception had been recently trained in conflict resolution. The practice had trained a health care assistant to check the register of patients every month who needed regular clinical monitoring because of the high risk medications that they were prescribed.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice had funded a health care assistant to train as an assistant practitioner starting in September 2016.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house and external training. Education and training for staff was fully supported by the practice and in-house clinical education events had been scheduled for every month until December 2017.
- One of the practice GPs had a special interest in dermatology and saw patients with skin problems in order to reduce referrals to other services.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. GPs from the practice contacted vulnerable patients when they were discharged from hospital to ensure that their needs were met. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

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.
- 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 identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients who may be experiencing memory loss. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group on the premises.
- A local organisation visited the practice every month to give advice on social care.
- The practice had close links with local rehabilitation services for patients who had been experiencing difficulties with drug and alcohol problems and provided health checks for those patients.
- The practice was proactive in identifying patients with undiagnosed chronic illness. It screened patients for

Good

Are services effective?

(for example, treatment is effective)

possible memory loss at influenza clinics one year and for possible heart problems the previous year. The practice then gave those patients appropriate care or signposted them to other services.

- There were other services in the building available for GPs to refer to such as physiotherapy, ophthalmology and orthopaedics.
- The practice's uptake for the cervical screening programme was 43%, which was lower than the clinical commissioning group (CCG) average of 69% and the national average of 82%. Due to difficulties in engaging patients to attend for cervical screening, the practice had participated in a local cancer screening initiative project during late 2015, early 2016. A member of the local black and minority ethnic (BME) network attended the practice and contacted patients who had failed to attend for cervical screening. The BME member made 239 telephone calls and spoke to 73 patients. Of those patients, 47 appointments were booked for the service and 41 attended. After this, a further 12 patients attended the screening because of the contact made. The practice hoped that this would encourage uptake in the future.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Patients who failed to attend bowel screening were sent a letter and a leaflet created by the practice to encourage attendance. Staff told us that they also planned to contact local mosque and temple leaders to ask them to promote the uptake of screening with their congregation.

Childhood immunisation rates for the vaccinations given were better than CCG averages for one year olds and under two year olds, and lower for five year olds. For example, childhood immunisation rates for the vaccinations given to one year olds ranged from 94% to 97% compared to CCG figures of 92% to 94% and for five year olds from 82% to 92% compared to the CCG figures of 91% to 96%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients 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 members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 23 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Staff were described as sympathetic and understanding.

We also spoke to five other patients who had attended the practice at their request to speak to us. They told us that they could not praise the practice highly enough for the care and treatment that they had received. They all praised the practice environment.

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

- 92% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG and national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

The practice invited local and national charities into the practice every other month to raise awareness of their work amongst the practice population. They were also able to raise funds for the charity for example by selling cakes and running raffles and competitions.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Some members of staff also spoke other languages. There was a poster in reception asking patients to identify and point to their language so that translation services could be arranged.
- Information leaflets were available in easy read format. The practice had also produced a number of its own leaflets that were relevant to the practice population such as the use of antibiotics, information on joint injections, patient use of steroids and keeping children and young people safe.
- The practice ordered and displayed special information posters during Ramadan in reception.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 108 patients as carers (1% of the practice list). They had appointed a member of staff to be a "carers' buddy" who was the first point of contact for carers. All carers were invited for an influenza vaccination. The practice had ensured that it had identified carers for patients receiving palliative care and those with dementia. Written information was available to direct carers to the various avenues of support available to them. The practice "carers' buddy" was also the "cancer buddy" for patients who had been diagnosed with cancer and provided a first point of contact at the practice for those patients.

The practice sent a congratulations card to all new mothers together with confirmation of a postnatal appointment at the surgery.

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

A nurse from the local hospice attended the practice weekly to support patients and their families and carers.

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. They had piloted a virtual multidisciplinary team project for the CCG whereby the practice made a regular daily telephone call with other members of community services to discuss vulnerable patients with complex needs who were at risk of hospital admission. Services then made arrangements wherever possible to manage these patients in their own homes.

- The practice offered a clinic on a Saturday morning between 8am and 12noon for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available. Some staff spoke languages in addition to English.
- GPs at the practice visited a local care home every week in order to provide more personal, timely care for complex patients with spinal injuries and to reduce unplanned admissions to hospital.
- The practice provided a clinic at the practice for patients who were taking anti-coagulant medication to prevent blood clotting. Patients were able to attend this clinic every week for monitoring blood-clotting levels instead of having to travel a considerable distance for the same service. We spoke to patients who praised this service.
- The practice told us they were about to commence a domiciliary monitoring service for housebound patients.
- There was a practice emergency access number that was available during practice opening hours when needed and was shared with care homes.
- The practice engaged with children by running competitions and by displaying pictures drawn by children in its waiting room. There was a large game painted on the waiting room floor.
- The practice gave the dedicated emergency number for the practice to the A&E department in order to work effectively with them in resolving the problem of patient frequent attendances at A&E.
- In order to better manage patient need for same day appointments, the practice mentored the pharmacist to become a non-medical prescriber and enabled him to see patients on the day that they presented at the practice.
- The practice had recognised the needs of Muslim patient families and had been the first practice in the area to work in partnership with the coroner and the Muslim burial committee. The practice had arranged for contact details to be shared so that timely access to these services was assured, particularly out of working hours. Details had also been shared with out of hours services. The practice shared this procedure with other practices locally for adoption.
- The practice had recognised that there was a need for better specialised care for patients with diabetes and had employed a GP with a special interest in diabetes. This GP held a clinic once a week at the practice to treat diabetic patients. We saw evidence that in the period of nine months that the GP had been at the practice, there had been better recognition of patients with diabetes and improvements in diabetic patient outcomes of treatment.
- The practice GPs also gave their mobile numbers to all patients and their families in an end of life situation and for some patients with complex needs. Patients we spoke to confirmed that they had been given a mobile number to contact the GP in emergency situations.

Access to the service

The practice was open between 8.30am and 6pm every weekday except Thursday when it closed at 1pm, and on Saturday between 8am and 12noon. Telephone lines to the practice opened at 8am on weekdays and closed at 6.30pm except on Thursdays when they closed at 1pm. New agreements with the local area team meant that from the end of August 2016, the practice would stay open on Thursdays until 6pm. Appointments were from 8.45am to 5.20pm daily and from 8am to 11.20am on Saturdays. GP clinics were staggered throughout the day to give morning,

Good

Are services responsive to people's needs?

(for example, to feedback?)

lunchtime and afternoon cover. 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 and telephone appointments. Patient appointments could also be booked online.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 74% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 78%.
- 66% of patients said they could get through easily to the practice by phone compared to the CCG and national average of 73%.

The practice had noted the results of the survey and had invested in a new telephone system which they hoped would increase patient access. They also extended the time that the telephone lines opened and closed by half an hour in the morning and the same in the evening and had started the Saturday morning surgery.

People told us on the day of the inspection that they were able to get appointments when they needed them. They said that sometimes they had to ring back if appointments were not available but that the wait to see a GP was not long. We saw that the next available routine appointment with a GP was on the following day and the same for a nurse.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Patient requests for home visits were listed on the practice's computer system and allocated to GPs within a limited timeframe to assess the urgency of need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The reception supervisor was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a practice complaints leaflet and a comments box in reception. Patients told us that they knew how to complain.

We looked at eight complaints received in the last 12 months and found they had all been dealt with in a timely way and with openness and honesty. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, when an error was made in issuing a prescription, staff were re-trained in the practice prescribing protocols.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a statement of purpose and core values and staff knew and understood the values.
- Within the last year, the practice had taken on the role of provider for three other practices in the area, one of which had moved into the premises, with a view to potentially merging with them. The practice had recently employed a service development manager to look at re-structuring the practice and to produce strategic business plans.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented. There was a folder of practice policies in the practice manager's office but staff were sometimes unsure as to where to access them. We were told that work was underway to ensure that they would soon be available on the practice intranet. There was no plan to ensure that policies and procedures were regularly reviewed.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, actions taken as a result of significant events were not routinely reviewed. The practice told us that they planned to involve an external organisation in providing health and safety risk assessments.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff were rewarded for their work with an annual weekend away, bonus payments and uniforms provided twice a year.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG was a mainly virtual group who met face-to-face occasionally. They were consulted regularly, carried out

Are services well-led?

Good

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

patient surveys and submitted proposals for improvements to the practice management team. For example, the practice car park was extended to provide more patient parking. The practice also started the Saturday morning surgeries and provided more telephone appointments as a result of patients asking for more appointment availability. The practice continuously sought patient engagement and involvement in the PPG and advertised the group in the waiting area and in the practice newsletter.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a 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. The practice had acted as the pilot site for receiving patient x-ray results electronically. It had also been the first practice in the area to use a pharmacist to see patients requesting to be seen that day. The practice had helped pilot the winter virtual multidisciplinary team daily meeting to discuss vulnerable patients at risk of hospital admission. The practice had been the first to use an external specialist online service for interpretation of electrocardiograph test results (ECG, a test to check the heart's rhythm and electrical activity) which had since been adopted by other local practice.

The practice worked extensively with local Muslim groups in order to respond better to their needs and had strong links with the community. They had improved communication for families of end of life patients enabling them to manage necessary arrangements in a timely way.

The practice was a training practice and provided support and mentorship to medical students and GP trainees at different stages of their learning.