Dr Amir Ipakchi (Also known as The Barbara Castle Health Centre)

Quality Report

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Date of inspection visit: 27 October 2014
Date of publication: 19/02/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

Our key findings were as follows:

- The practice had comprehensive systems for monitoring, responding to and learning from incidents when things went wrong.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was responsive to the needs of patients and operated a flexible system for routine and health review and promotion appointments.
- The practice performed above or in line with local and nationally set targets for assessing and meeting the needs of patients.
- The practice was well managed with staff and patients reporting that they felt valued and were involved in making decisions.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that patients and staff are protected against the risks of health acquired infections by carrying out periodic audits to test the effectiveness of the practice infection control procedures and other risks associated with the premises, making improvements to these practices where this is required.

In addition the provider should:

- Ensure that all staff who carry out chaperone duties undertake appropriate training in respect of their roles and responsibilities.

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 safe as there are areas where improvements should be made.

Staff understood their responsibilities to raise concerns, and report incidents and near misses. There were processes for learning from incidents and improving patient safety where needed.

The practice had systems in place for assessing risks of health acquired infections and there were policies and procedures in place. However, no infection control audits had been carried out to test the effectiveness of these procedures and practices. There were no health and safety risk assessments in place to identify and manage risks to patients and staff.

The practice had fire safety procedures in place. However improvements were needed to ensure that these procedures were followed. For example no fire drills and evacuation exercises had been carried out.

There were policies and procedures in place for providing chaperones during physical examinations. However none of the staff who acted in a chaperone role had undertaken training to ensure that they fully understood their responsibilities.

Are services effective?

Good

The practice is rated as good for effective. Data we had access to showed that the practice was achieving results that were in line or better than the national or local Clinical Commissioning Group average in all areas of assessment and delivery of patient care. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) and local guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation.

The practice was proactive in the care and treatment provided for patients with long term conditions such as asthma and diabetes and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for most aspects of care. Patients

Summary of findings

told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that emergency appointments were available the same day.

There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients and this was acted upon. The practice had an established patient participation group (PPG). A patient participation group is a forum made up of patients and staff who meet to share information and help influence changes and improvements in general practices. There was evidence that the practice had a culture of learning, development and improvement.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 15 CQC comment cards patients had completed and by speaking in person with five patients, one of whom was involved with the practice Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers

and members of a GP practice team. The purpose of a PPG is to work in partnership with the practice to promote and improve how the service is provided. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the NHS England GP patient survey showed that the practice scored in the upper range nationally for satisfaction with the practice. The practice scored highly for patient satisfaction with the availability of appointments, their involvement in making decisions about their care and treatment and how they were treated by staff.

Areas for improvement

Action the service MUST take to improve

- Ensure that patients and staff are protected against the risks of health acquired infections by carrying out periodic audits to test the effectiveness of the practice infection control procedures and other risks associated with the premises, making improvements to these practices where this is required.

Action the service SHOULD take to improve

- Ensure that all staff who carry out chaperone duties undertake appropriate training in respect of their roles and responsibilities.

Dr Amir Ipakchi (Also known as The Barbara Castle Health Centre)

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP and a practice nurse specialist advisor.

Background to Dr Amir Ipakchi (Also known as The Barbara Castle Health Centre)

Dr Amir Ipakchi is located on the outskirts of Harlow Town. The practice provides services for approximately 5,000 patients living in the area The practice has no branch surgeries.

The practice is managed by Dr Amir Ipakchi. The practice employs one long term locum GP, two practice nurses and a team of administrative and reception staff who support the practice.

Dr Amir Ipakchi is not a teaching practice. The practice does not provide dispensing services.

The practice is open between 8.30am and 6.30pm on weekdays. Appointments are available from 9.30am to 12.30pm, and 1.30pm to 6pm. Home visits and telephone consultations were available as required.

Dr Amir Ipakchi does not provide an out-of-hours service to patients. Details of how to access out-of-hours emergency and non-emergency treatment and advice was available within the practice and on its website.

Why we carried out this inspection

We inspected Dr Amir Ipakchi (Also known as The Barbara Castle Health Centre) 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?

Detailed findings

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 October 2014. During our visit we spoke with a range of staff including GP's, practice nurses, reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Dr Amir Ipakchi had opted out of providing out-of-hours services (evenings and weekends). These services were provided by a local out-of-hours service and details of how to contact the service was available within the practice and on the practice website.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety.

Complaints, accidents and other incidents such as significant events were reviewed regularly to monitor the practice's safety record and to take action to improve on this where appropriate. We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Accidents, significant events and any other safety incidents were fully investigated and a root cause analysis was carried out to help determine a timeline of events and what had gone wrong.

Records were kept of significant events that had occurred during the last twelve months and these were made available to us. All on-going significant events, concerns or complaints of a serious nature were discussed with staff during the weekly practice meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Investigations into safety incidents were reviewed periodically to ensure that staff learning was embedded in practice and patient safety was improved. For example we saw evidence of learning and improvement to the procedures for ensuring that appropriate referrals were made to specialists following a delay in referral for one patient.

Staff including receptionists, administrators and nursing staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding adults and children. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated lead for safeguarding vulnerable adults and children who had oversight for safeguarding and acted as a resource for the practice. Staff we spoke with were aware of whom the lead was and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example cared for children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed at weekly GP meetings and monthly multidisciplinary team meetings which were attended by health visitors, district nurses and school nurses. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed followed up, and appropriate referrals were made as required.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff. The GP's and nurses told us that nurses would usually act to chaperone patients , although reception staff would

chaperone if a nurse was not available. Reception staff had not undertaken chaperone training and had access to written guidelines provided by the local Clinical Commissioning Group (CCG). Patients we spoke with were aware that they could request a chaperone during their consultation, if they chose to.

Patient's individual records were written and managed in a way which helped ensure safety. Records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that staff had undertaken training in the use of the electronic system and audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

Medicines were managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for antibiotics, hypnotics and non-steroidal anti-inflammatory medicines were similar to the national average. Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets and posters, and on the practice website. Patients could order repeat prescriptions in person, by fax, post or by email. There were appropriate systems in place for ensuring that patients repeat prescriptions were checked and that patients' blood levels were routinely monitored to ensure that medicines were prescribed safely and effectively.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were explained fully.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

We saw there were cleaning schedules in place for general and clinical areas and cleaning records were kept. There were infection control policies and procedures for staff to follow, which enabled them to plan and implement control of infection measures. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections. All clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. The GP confirmed that while checks were carried out to ensure that the practice was clean, that no infection control audit had been carried out to test the effectiveness of the infection control procedure and practices.

The practice had a policy for the management, testing and investigation of legionella (a bacteria found in the

environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales, thermometers and emergency equipment such as an automatic external defibrillator (used to attempt to restart a person's heart in a cardiac emergency) were periodically checked and calibrated to ensure accurate results for patients. The GP confirmed that equipment had not been portable electronic appliance (PAT) tested. They told us that visual checks were carried out on all equipment to help identify any defects or safety issues. PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use. Most electrical defects can be found by visual examination but some types of defect can only be found by testing. The GP assured us that these checks would be carried out.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. Employment references and criminal records checks were obtained for all newly appointed staff before they started work at the practice. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us there were always enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures), or adverse weather conditions. Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, which staff were aware of. The GP confirmed that the practice did not have a health and safety risk assessment in place. They told us that the property landlord had previously held responsibilities for the maintenance of the safety of the premises. However this had recently changed and these responsibilities were transferred to the practice. The GP told us that they were planning a review of the health and safety within the practice and would complete a thorough risk assessment as part of this process.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Staff had access Resuscitation Council (UK) guidelines to assist in dealing with medical emergencies. Emergency equipment and medicines were available at a dedicated place within the practice, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in a cardiac emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (allergic reactions) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Requires improvement

Are services safe?

A comprehensive business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. The GP confirmed that fire drill and evacuation exercises were not carried out and assured us that these would be implemented.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information, new guidance and changes to current guidelines was made available in information folders and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments. We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance for antibiotic prescribing was comparable to similar practices.

The practice GP's took a lead role in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. The practice nurses carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This helped the GP's to treat patients with more complex medical conditions.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. The GPs told us clinical audits were often linked to medicines management information, safety alerts. We saw that clinical audits had been carried out around the treatment of conditions such as type 2 (insulin dependent) diabetes, and the use of anticoagulants (medicines used to prevent the risks of blood clots) such as warfarin so as to ensure that medical conditions and prescribing practices were in line with current National Institute for Health and Care Excellence (NICE) guidelines, in the best interests of patients and cost effective.

We looked at the data and information we had about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was in line with or higher than the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as diabetes, dementia, learning disabilities and mental health disorders and those with life limiting conditions.

The practice administrator was responsible for sending out letters inviting patients with one or more long term condition to attend their annual reviews. Patient attendance was monitored and followed up to help ensure that patients attended their review appointments

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Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff described the process for ensuring that repeat prescriptions were checked and reviewed and the processes for alerting the GP's if they had any concerns about repeat prescriptions. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs reviewed the use of the medicine in question, prescribed alternatives or, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs and reviewed their treatments appropriately.

Effective staffing

The practice employed staff who were appropriately skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for four members of staff. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current

Good

Are services effective?

(for example, treatment is effective)

professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Staff we spoke with told us that the GP provided opportunities for learning and that they undertook training in protected time known as 'Time to Learn'.

All new staff underwent a period of induction to the practice. There were tailored induction packs to support new staff according to their role and job description. Support was available to all new staff to help them settle into their new role and to familiarise themselves with relevant policies, procedures and practices.

Individual staff performance was assessed and training and development needs were identified through an annual appraisal system. Staff had personal development plans that detailed their planned learning and development objectives, which were kept under review. We saw that where staff had identified training interests that arrangements had been made to provide suitable courses and opportunities. Nursing staff told us that they received regular clinical supervision, support and advice from the GPs when needed. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had named GP's and nurses to act as leads for overseeing areas such as safeguarding, infection control, palliative care and treatment and staff training. Both nurses had undertaken specific training in the treatment of minor illness such as colds, flu, acute asthma, digestive complaints and urinary tract infections. Nurses provided services including well person checks, long term condition reviews, family planning and cervical screening. This enabled the doctors to focus on more complex problems and conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were attended by district nurses, health visitors, social workers and palliative care nurses where decisions about care planning were documented in a shared care record. We looked at the records for the last six meetings and found that detailed information was recorded, reviewed and shared to ensure that patients received coordinated care, treatment and support.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had undertaken training on the system. Staff told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care. We saw that treatment records for patients who had used the out-of-hours service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment

GPs and nurses at the practice worked closely with MacMillan nurses who support people with life limiting illnesses. They held a monthly palliative care meeting with other doctors, nurses, healthcare assistants and MacMillan nurses attending to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs.

Staff were alert to the importance of only sharing information with patients or with patients' consent and gave us an example of a situation where a receptionist had checked a request with a GP.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Both nurses we spoke with were aware of parental responsibilities for children and they told us that they obtained parental consent before administering child immunisations and vaccines.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Nurses and GPs we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so by ensuring that any decisions made on their behalf are in the person's best interests.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, reception and entrance hall where patients could see them. These included information to promote good physical and mental health and lifestyle choices. We saw information about mental health domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice and on the practice website.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led clinics and pre-booked appointments were available including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma clinics.

Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Data we looked at before the inspection showed that the practice was performing in line with other practices in the area for take up of childhood immunisations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 15 CQC comment cards that patients had filled in and spoke in person with five patients, one of whom was involved with the Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients said they felt the practice provided excellent care and treatment. Patients commented that staff were kind, efficient, helpful and caring. They said staff listened to them sympathetically and were respectful and treated them with dignity.

We reviewed the most recent information available from the national patient survey, which was carried out in 2013. This showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example 86% of patients who completed the national patient survey described their overall experience of the practice as good and 78% would recommend the surgery. The practice also scored highly for responses from patients relating to GP's giving them enough time, involving them in making decisions about their care and treating them with care and concern.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. Reception staff told us that where patients wished to speak privately to a receptionist were offered the opportunity to be seen in another room. During the inspection we spent time in the waiting room and reception. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so.

The practice was located in a single storey building and was easily accessible to patients with mobility issues. There were hearing loop facilities for patients who were hearing impaired.

The practice had a range of anti-discrimination policies and procedures and staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The patient national GP survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 79% of practice respondents said the GP involved them in care decisions and 81% felt the GP was good at explaining treatment and results. These results were in line with or above local and national averages. Patients we spoke with during the inspection told us that nurses and GP's were extremely caring and spent time ensuring that they understood their treatment.

Patients we spoke to on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that information in relation to their health and the treatment that they received was explained to them in a way that they would understand. Patient

Good

Are services caring?

feedback on the comment cards we received was also positive the majority of the 15 patients who responded told us that they were happy with their involvement in their care and treatment.

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

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were invited to complete a 'carers registration' so that they could be identified and provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families. For example patients and carers were advised of the local hospice 24 hour helpline.

Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at the practice, or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

The practice provided general practice cover to approximately 30 patients living in two local care homes. We spoke with the managers of both these care homes about the service people received from Dr Amir Ipakchi. Both were positive about the service. They told us that the GP was polite, respectful and kind to their patients and listened to them. Both managers confirmed that the GP worked with them to review each person's health and medicines.

Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from varied ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice manager told us that a small number of patients were from the travelling population. The GP told us that staff had worked to build relationships with these patients and that the majority attended appointments for health screening and checks, including baby and child immunisations and vaccinations.

Patients who needed extra support because of their complex needs were allocated a longer time for their appointments. We saw specific tailored care plans to meet their needs of patients with learning disabilities and for those affected by dementia as well as those with long term medical conditions.

Access to the service

Staff at the practice understood the needs of the practice populations and had developed an appointments system to meet the needs of patients from the different population groups. Details of the services available, how to book, change or cancel appointments were posted throughout the practice and displayed on the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Patients we spoke with and those who completed a CQC comment card did not have any concerns about accessing appointments. A number of patients commented about the ease of making same day appointments for urgent assessments and treatment. We looked at data from the national GP Patient Survey carried out in 2013. From this we found that the practice was among the best for patients who expressed satisfaction with the practice opening hours and access to appointments.

Appointments were available between 9.30am and 12.30pm, and between 1.30pm and 6pm. Routine appointments could be pre-booked up to two weeks in advance. Staff told us that this helped to minimise the number of non-attended appointments. Staff showed us the arrangements for monitoring the availability of appointments and non-attended appointments. These were reviewed weekly to help ensure that patients were provided with a flexible and reliable appointments system. The practice did not offer extended hours; however the GP and patients confirmed that evening appointments were available depending upon individual's needs. Patients commented that Dr Ipakchi was very accommodating and provided appointments and telephone consultations up to 6.30pm if needed.

The practice is located in a single building with wheelchair accessible access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns & complaints

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

There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. This information included details of the timelines for

Good

Are services responsive to people's needs?

(for example, to feedback?)

investigating and responding to complaints and concerns. This information was available within the practice and on the website. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Staff were aware of these procedures and the designated person who handled complaints. Doctors, nurses and administrative staff told us that the practice had an open culture where they felt safe and able to raise concerns. They told us learning from complaints and when things went wrong was shared through meetings and that there were mechanisms in place for making improvements as needed to help minimise risks and improve patients experiences.

We looked at the records for the six complaints received in the last twelve months and found these were investigated thoroughly and sensitively. All complaints whether written or verbal were recorded and investigated consistently in line with the practice's complaints procedures. Records we viewed showed that there were learning outcomes from complaints where appropriate and that these were shared with staff to help improve practices and patient care.

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 and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were aware of the vision, values and future plans for the practice. The practice team shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. The practice charter, which was available in written form and on the website promoted an ethos by which patients were responsible and in charge of their healthcare. Patients we spoke with confirmed that they were encouraged and supported to do so.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews, audits and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. The majority of staff had lead roles, these included infection control, palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

The practice held a monthly clinical meetings and discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working and in practice. The practice had robust systems for monitoring and reviewing the delivery of patient care and treatment.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. We saw examples of completed clinical audit cycles demonstrating that the practice was reviewing and evaluating the care and treatment patients received.

Leadership, openness and transparency

All staff we spoke with told us that all members of the Barbara Castle Health Centre were approachable. They were encouraged to share new ideas about how to improve the services they provide. Staff spoke positively and passionately about the practice and how they worked collaboratively with colleagues and health care professionals. Staff told us that they felt very well supported within the practice. They told us that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held a short team meeting each morning before surgery started to discuss and plan their day.

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

The practice had an active Patient Participation Group (PPG) The practice had established a Patient Participation Group. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Members of the patient group said that they were able to help inform and shape the management of the practice in relation to patient priorities, any planned practice changes and the outcomes from local and nation GP survey.

Patients we spoke with told us that they were aware of the patient group. Those who were unable to be part of this group told us that they were always listened to by staff at the practice. The practice website offered patients opportunities to make comments about the service and information was also displayed within the practice.

Are services well-led?

Good

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

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality patient care. We saw that there were robust arrangements for learning from incidents, significant and serious events and complaints. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five 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 protected time for learning and personal development.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have suitable systems in place for monitoring and improving where necessary the quality and safety of services.** **There were no systems in place for testing the effectiveness of the infection control procedures within the practice. There were also no systems for carrying out health and safety risks assessments and managing risks where these were identified.**