

Dr.A.Singh and Dr.S.Bicha

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Key findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. There has been a previous inspection at this practice in February 2016 and the practice was rated – Requires Improvement overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Dr.A.Singh and Dr.S.Bicha on 13 March 2018. Overall the practice is rated as Good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. Sharing information and lessons learnt with external providers required improvement.
- The practice had systems, processes and practices in place to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Good training opportunities were seen for staff but infection control training had not been completed for staff.
- The practice had systems 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. However, this was undertaken on an ad hoc basis and there was no robust system to ensure all guidelines issued had been followed.

Summary of findings

- Staff sought patients' consent to care and treatment in line with legislation and guidance. When questioned however, not all staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- The practice understood its population profile and had used this understanding to meet the needs of its population
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns. However, formal action plans were not routinely developed following a patient complaint.
- Patients reported 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.
- Governance systems were implemented and reviewed on an ad hoc basis rather than as part of a clear governance framework. A programme of continuous clinical and internal audit was not evident during the inspection.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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 the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We identified regulations that were not being met and the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

There were areas where the provider could make improvements and should:

- Review all significant events on an annual basis to identify themes and trends. They should review the processes in place for sharing the outcomes of significant investigations with external agencies when required.
- Review the system in place for ensuring guidelines from NICE are used and monitored to deliver care and treatment that meet patients' needs.
- Review the infection control training opportunities for staff.
- Review the assurance process for ensuring patients on high risk drugs are monitored.
- Review the workload of the practice nurse to ensure adequate time is available to attend local peer group meetings.
- Review how effective care plans can be used by the practice to deliver care and treatments.
- Review how lessons are learnt and practice is changed and monitored with action plans as a result of patient complaints.
- Review how practice policies and procedures are updated.
- Review the training opportunities for staff relating to the consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Develop a management system to ensure that the premises are maintained by the host organisation, this should include annual assurance that health and safety risk assessments required have been completed and any issues identified have been addressed.

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

Key findings

Areas for improvement

Action the service **MUST** take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service **SHOULD** take to improve

- Review all significant events on an annual basis to identify themes and trends. They should review the processes in place for sharing the outcomes of significant investigations with external agencies when required.
- Review the system in place for ensuring guidelines from NICE are used and monitored to deliver care and treatment that meet patients' needs.
- Review the infection control training opportunities for staff.
- Review the assurance process for ensuring patients on high risk drugs are monitored.

- Review the workload of the practice nurse to ensure adequate time is available to attend local peer group meetings.
- Review how effective care plans can be used by the practice to deliver care and treatments.
- Review how lessons are learnt and practice is changed and monitored with action plans as a result of patient complaints.
- Review how practice policies and procedures are updated.
- Review the training opportunities for staff relating to the consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Develop a system to ensure that the premises are maintained by the host organisation, this should include annual assurance that health and safety risk assessments required have been completed and any issues identified have been addressed.

Dr.A.Singh and Dr.S.Bicha

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.

Background to Dr.A.Singh and Dr.S.Bicha

Dr.A.Singh and Dr.S.Bicha is registered with CQC to provide primary care services, which include access to GPs, family planning, ante and post-natal care. The practice is a newly formed GP partnership working in the centre of Liverpool in a deprived area of the city. The practice has a General Medical Services (GMS) contract with a registered list size of 2434 patients (at the time of inspection). The practice had a high proportion of patients between the ages of 25-34.

The practice has two GP partners, male and female, a practice nurse and a number of administration and reception staff. The practice operates from 8am to 6.30pm daily. Patients can book appointments in person, via the telephone or online. The practice provides telephone consultations, pre-bookable consultations, urgent consultations and home visits.

The practice treats patients of all ages and provides a range of primary medical services. Home visits and telephone consultations were available for patients who required them, including housebound patients and older patients. There are also arrangements to ensure patients receive urgent medical assistance out of hours when the practice is closed.

The practice offers a range of enhanced services including spirometry, near patient testing, flu and shingles vaccinations, anticoagulant monitoring and joint injections.

The practice is part of the Liverpool Clinical Commissioning Group.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had some but not all the required systems to keep patients safe and safeguarded from abuse.

- Arrangements for safeguarding did not reflect relevant legislation and local requirements. Policies observed on the day of inspection for safeguarding children had not been updated for some time and did not reflect updated guidance and legislation. After the visit an updated policy was submitted to us with a plan for implementation. The practice had contact details for who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. However, not all GPs and nursing staff were trained to child protection or child safeguarding level three. Confirmation that issues raised had been addressed was sent to us following inspection.
- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The GP partner was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol however, staff had not completed up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. For example, electrical equipment was checked to ensure it was safe to use, clinical equipment was checked to ensure it was working properly and checks of the fire safety systems were carried out. We reviewed a sample of records that indicated the premises were safely maintained however, not all of this was available at the time of inspection and later had to be sent across to us.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. On the day of inspection two of these medicines were out of date. Immediate actions were taken and confirmation was received following inspection that these had been updated and new systems for checking was now in place.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had some reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. We were told that repeat prescriptions were signed before being dispensed to patients on high risk medicines however, there was no formal assurance process in place to ensure this occurred.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

There was a system 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 in paper format for staff to complete. 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).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports and minutes of meetings where significant events were discussed.
- A new paper system for managing and responding to patient safety alerts had been implemented.
- We saw evidence that lessons were shared and action was taken to improve safety when events were happening at the practice. For example, when errors were made to the ordering of prescriptions new systems and checks were put in place to prevent this happening again. However, when investigation of a significant event took place that identified learning should take place with an external agency or organisation, this had not been shared locally.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice and all of the population groups as Requires Improvement for providing effective services.

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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 meet patients' needs. However, this was undertaken on an ad hoc basis and there was no robust system to ensure all guidelines issued had been followed.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older People

- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.
- The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care.
- The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Attached to the practice were community matrons and district nurses who work closely with the team managing the patients in the care homes in the area.

- Flu vaccinations and Pneumonia vaccinations were offered to patients with shingles vaccination for the relevant age groups.

People with long term conditions

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice was comparable to other similar practices for the management of patients with long term conditions. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 70.4%, which is comparable to the local and national average.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for 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.

Families and young children

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group.

Are services effective?

(for example, treatment is effective)

- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students):

- The practice's uptake for the cervical screening programme was 68%, which was comparable with the CCG average of 68% and the national average of 72%.
- The practices' uptake for breast and bowel cancer screening was just below the national average. The practice was aware of this and the practice nurse was making efforts to improve this result.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances may make them vulnerable

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- 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 had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. However, safeguarding arrangements were not safe.

People experiencing poor mental health (including people with dementia)

- The practice carried out advance care planning for patients living with dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Data showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months, which is comparable to the local and national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Monitoring care and treatment

The practice did not have a comprehensive programme of quality improvement activity and did not review the effectiveness and appropriateness of the care provided routinely.

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 513 of the total number of points available which was 559.

Are services effective?

(for example, treatment is effective)

This practice was an outlier for a small number of indicators for QOF (or other national) clinical targets. Data from 2016/2017 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. However, for the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less Include example data the result was 58% when the national average was 78%. The practice was aware of this and actions were taken to improve this result, such as working closely with the Diabetes Specialist Nurse to review complex patients.
- Performance for mental health related indicators was similar to the CCG and national averages. However, for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months the practice result was higher than the local and national figures with 100% achievement.

There was limited evidence of quality improvement including clinical audit shown during the inspection. We saw that an anti-biotic audit had been completed and there were signs the practice had improved services in response to the results for this. However, there was no evidence that audits had been repeated or monitored further.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge 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 and those requiring family planning.
- 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 nurse however, did not have the time to attend local practice nurse meetings where updates and discussions would take place.

- 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 and nurses. 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 and in-house training. Infection control training for staff had not been completed.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

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. Information was shared between services, with patients'

Are services effective?

(for example, treatment is effective)

consent, using a shared care record. Meetings took place monthly with other health care professionals on a monthly basis when records were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- There was a policy to offer telephone or written 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. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were

systems 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.

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- However, when questioned not all staff were understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Some but not all staff had completed this training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent
- 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.
- There was no evidence that the process for seeking consent was monitored through patient records audits.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

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

- 85% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 88%.
- 94% 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%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 100% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.

All of the 32 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 were told that GP and nurses took time to listen to patients. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 32 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. We were told that older carers were offered timely and appropriate support.

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 or at times below local and national averages. For example:

- 77% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

Are services caring?

- 98% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 89%.
- 99% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

Privacy and dignity

The practice respected/did not respect patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could not be overheard by patients in the waiting room.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Wednesday evening until 6.30pm for working patients needing to see the nurse 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.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and on-going conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice worked closely with the local Mental Health Trust community liaison worker to meet the needs of patients

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

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

- 85% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 84% and the national average of 80%.
- 82% of patients said they could get through easily to the practice by phone compared to the national average of 70%.
- 65% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 74% and the national average of 75%.

- 80% of patients described their experience of making an appointment as good compared with the CCG average of 76% and the national average of 72%.

The practice had a system to assess:

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

This was undertaken by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical 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 took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Two complaints were received in the last year. We reviewed both complaints and found that they were satisfactorily handled in a timely way.
- Lessons were learned from individual concerns and complaints but formal action plans had not been identified to enable the practice to monitor that actions were taken to as a result to improve the quality of care.

Are services well-led?

Good 

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

Our findings

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a vision and worked toward their own strategy to deliver high quality, sustainable care. All staff we spoke with spoke of a clear set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work however, there was not sufficient time to attend local peer group meetings.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

The practice undertook a number of governance activities however, some systems had been implemented and reviewed on an ad hoc basis. We found that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, infection control and safeguarding leads were in place.
- There was a system for reporting and recording significant events and responding to patient complaints.
- A new paper system for managing and responding to patient safety alerts had been implemented.
- We reviewed personnel files and found
- There were procedures for assessing, monitoring and managing risks to patient and staff safety.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- Practice specific policies were implemented and were available to all staff. Staff were aware of these, however, there was system in place to ensure these remained updated and reviewed regularly.
- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used

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this information to deliver care and treatment that met patients' needs. However, this was undertaken on an ad hoc basis and there was no system to ensure all guidelines issued had been followed.

- Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.
- 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.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was not evident during the inspection.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, infection control risks.
- We saw evidence from minutes

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice encouraged and valued feedback from patients and staff.

- It proactively sought feedback from patients at an organised coffee morning event in August 2017. Patient surveys were carried out at this time and face to face meetings with patients were held. The practice collected the views of nine patients on this day and where improvements were suggested by patients, for example, for concerns raised about waiting times for GPs, actions were implemented to improve this.
- The NHS Friends and Family test, complaints and compliments received
- Staff views were gathered generally through staff meetings, appraisals and discussion. Staff told us they

Are services well-led?

Good 

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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 and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. This included the practice working closely with the Diabetes Specialist Nurse for complex patients.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice offered a comprehensive, discreet and confidential family planning clinic by experienced GPs and practice nurses when family planning clinics were stopped in the local community.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Governance systems were implemented and reviewed on an ad hoc basis rather than as part of a clear governance framework. There was limited evidence of continuous clinical and internal audit.</p> <p>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>