Dr Siraj Shah

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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Siraj Shah on 21 February 2017. 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.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff understood their responsibilities to raise concerns and report incidents and were fully supported to do so.
- Safeguarding vulnerable adults, children and young people was given priority. Staff took a proactive approach to safeguarding, responded appropriately to signs or allegations of abuse and engaged effectively with relevant organisations to implement protection plans.
- 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.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing. Care and treatment was regularly reviewed and updated.
- Data from the Quality and Outcomes Framework showed patient outcomes were below or comparable to the national average. However, The practice did not consistently use the Quality and Outcomes Framework and the data was therefore not reliable.
- The practice used a system of searches, flags and pop up alerts to identify the care and treatment needs of patients with long-term conditions.
- Clinical audits were carried out and these were completed audits which demonstrated quality improvement.
- The practice's uptake for the cervical screening programme was 65%, which was highlighted as a significant negative variation from the clinical commissioning group (CCG) average of 87% and the

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national average of 81%. However, the practice had a consistent high level of non-attenders, and provided clear evidence of regular follow ups to engage these patients.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good 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 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.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- Safeguarding vulnerable adults, children and young people was given priority. Staff took a proactive approach to safeguarding, responded appropriately to signs or allegations of abuse and engaged effectively with relevant organisations to implement protection plans.
- Staffing levels and skill mix are planned, implemented and reviewed to keep people safe
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- The practice did not consistently use the Quality and Outcomes Framework and the data was therefore not reliable.
- The practice used flags and pop up alerts to care for patients with long-term conditions.
- Staff were aware of current evidence based guidance.
- Clinical audits were carried out and these were completed audits which demonstrated quality improvement.
- The practice's uptake for the cervical screening programme was 65%, which was highlighted as a significant negative variation from the clinical commissioning group (CCG) average of 87% and the national average of 81%. However, the practice had a consistent high level of non-attenders, and provided clear evidence of regular follow ups to engage these patients.

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- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Staff responded compassionately when people needed help and support.
- Fifty-one CQC comment cards were received and these were all positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice had taken part in a diabetes pilot to help address the needs of the patient population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from four examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In four examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. For example, 100% of patients who were unable to get to the practice had received their flu vaccine.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice had a higher than average level of patients with diabetes.
- The practice had committed to a CCG driven diabetes pilot, where a Specialist Nurse Practitioner held two clinics per month and supported patients with diabetes.
- 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

Summary of findings

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, children and young people

Good

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

- 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 variable for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice provided ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications and were able to demonstrate this.

Working age people (including those recently retired and students)

Good

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

- The needs of these populations 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 on a Monday evening until 8pm.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- Ultra-sound scanning (unfunded) was available at the practice and was offered to patients in place of pregnancy tests.

Summary of findings

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, asylum seekers in sheltered housing, 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 and ensured that where vulnerable patients did not attend they were telephoned and an alternative appointment arranged.
- 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. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.
- 67% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG and national average of 84%.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 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 acted to support patients in mental health crises.

Summary of findings

- 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.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice was performing in line with local and national averages. 287 survey forms were distributed and 105 were returned. This represented 4% of the practice's patient list.

- 76% of respondents described the overall experience of this GP practice as good compared with the CCG average of 82% and the national average of 85%.
- 78% of respondents described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.
- 76% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 75% and the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 51 comment cards which were all positive about the standard of care received. Key themes that reoccur within the comment cards are that patients feel listened to and cared for by the GPs and nurse; that diagnoses were explained and referrals made as necessary; that the service is professional; the receptionists helpful; the premises clean and hygienic and that patients are treated with kindness, dignity and respect.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Dr Siraj Shah

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP Specialist Adviser and an Assistant CQC Inspector.

Background to Dr Siraj Shah

Dr Siraj Shah is situated in Gravesend, Kent and has a registered patient population of approximately 2750. The practice is housed in an adapted building which has been extensively renovated providing improved access to patients and an improved working environment for staff. The premises has consulting and treatment rooms based on the ground floor and administration rooms and a meeting/training room on the first floor. The building is accessible for patients with mobility issues and those with babies/young children. There are parking facilities available in a public car park next to the practice.

The practice patient population mostly compares to the England average in terms of age distribution, however, there are more patients from the age of 0 and 4, more male patients from the age of 25 and 34 and more female patients from the age of 25 and 29.

It is in an area where the population is considered to be more deprived. On the Indices of Multiple Deprivation (IMD) decile the practice is rated at 4 across England, with 1 being most deprived and 10 being least deprived. The practice is the 5th most deprived borough within the county of Kent. The practice serves a large Asian and Afro-Caribbean community.

The practice provider registration consists of one GP partner (male) and one practice manager partner. There is one practice nurse and administration and reception staff. Three partners from a separate practice have recently joined Dr Shah, each working one day a week. One of these partners is female and she provides patients with access to a female practitioner. The two practices work together to share resources and personnel and to provide patients with a wider range of services. There is also a male salaried GP who works one day each week.

The practice is not a teaching or training practice (teaching practices have medical students and training practices have GP trainees and FY2 doctors).

The practice has a Primary Medical Services contract with NHS England for delivering primary care services to the local community.

The practice is open from Monday to Friday from 8.30am until 1pm and from 2pm until 6.30pm. The telephone lines are open from 8am and during the lunch break period. Extended hours appointments are available every Monday evening from 6.30pm until 8pm with a GP or a practice nurse. In addition to routine appointments that can be booked in advance, urgent on the day appointments are available for people that need them. Appointments can be booked over the telephone, online or in person at the practice. There are arrangements with other providers (Integrated Care 24) to deliver services to patients outside of the practice's working hours.

The practice runs a number of services for its patients including; family planning; minor surgery; chronic disease management; NHS health checks; immunisations and travel vaccines and advice.

Services are provided from: Parrock Street Surgery, 186 -187 Parrock Street, Gravesend, Kent DA12 1EN.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 February 2017. During our visit we:

- Spoke with a range of people including GPs, the practice nurse, the practice manager and reception/admin staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

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 on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From a selection of 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, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice.
- The practice also monitored trends in significant events and evaluated any action taken. For example, where there was a trend of misdiagnosis from an outside agency, the practice reported this and the learning was shared within the staff team. The practice also shared significant events and learning from these with colleagues from other practices at learning events.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From a selection of documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. The practice were active in making referrals to other agencies where concerns were identified and pursued these to help ensure patient safety.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse 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 and staff had received up to date training. Annual IPC audits were undertaken as part of the health and safety risk assessment and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice was a low prescriber of anti-biotics and their prescribing performance had continued to improve. The practice was a cost effective

prescriber. Blank prescription forms were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice manager had carried out a time and motion study to identify areas of greatest need so that staff could be appropriately deployed.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received basic life support training and the annual update was carried out at the practice in February 2017. There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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 met patients' needs.

Management, monitoring and improving outcomes for people

The practice did not consistently engage in the Quality and Outcomes Framework (QOF) and therefore information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients may not accurately reflect their achievement. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 78% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%.

The overall exception rate for the practice was 6% which was comparable to the CCG average of 7% and the same as the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice were aware of their QOF score and staff told us that a focus on the patient and continuity of care took precedence.

This practice was an outlier for a number of QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators were variable. For the period between 01/04/15 and 31/03/16 two negative variations were identified where the indicators were lower than the CCG and national averages. For example:
- The percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c was 64 mmol/mol or less in the preceding 12 months was 58% compared to the CCG average of 77% and the national average of 78%
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 65% compared to the CCG average of 78% and the national average of 80%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 83% which was comparable to the CCG and national average of 78%.

The practice had a high level of patients with diabetes. 199 of their 2700 registered patients had been diagnosed with the disease and the prevalence of diabetes was 7% compared to a national prevalence of 7% (this was not CQC verified data).

The practice used a system of daily searches to monitor patients requiring follow-up investigations or clinical reviews and a series of flags and pop up alerts when the patient record was accessed highlighted the interventions required for patients. The practice effectively used this as a system to recall patients with diabetes and other long term conditions for a clinical review.

The practice had committed to a diabetes pilot in collaboration with the CCG in May 2016 whereby a diabetes specialist nurse attended the practice twice each month to help to improve outcomes for patients with diabetes.

The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway was 75% compared to the CCG and national average of 49%. A high cancer detection rate could improve early diagnosis and help to enable the timely treatment of patients and positively impact on their survival rates.

Performance for mental health related indicators were lower than the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their patient record, in the preceding 12 months was 30% which was a significant variation on the CCG and national average

Good

Are services effective?

(for example, treatment is effective)

of 89%. The practice had 23 patients who were identified as fitting this diagnosis and had a 0% exception rate compared with a 15% exception rate at CCG average and 13% at national average.

Personalised care plans were examined for patients with mental health diagnoses and these were completed in detail and the patients were reviewed regularly. Documents presented demonstrated that patients with mental health needs were well supported by the practice and there was evidence of immediate responses to urgent situations with positive results.

Staff told us that there has been limited time to complete the coding required for QOF indicators and that this may have impacted on accuracy and resulted in figures that appeared lower than they were.

There was evidence of quality improvement including clinical audit:

- There had been number of clinical audits undertaken in the last two years, and these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, the practice had carried out a diabetes audit in 2015 and committed to a CCG led pilot to help improve outcomes for patients. A second audit completed in 2016 demonstrated that there was improvement for patients in controlling their diabetes.

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 induction process included a period of shadowing appropriate to the joining staff member and a tailored training programme.
- 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 by ongoing training and protected learning time.
- 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 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 and this was a reflective process where personal and practice specific goals were set and monitored. Six monthly reviews were also held.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house training and external training providers.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on an as needed basis, and care plans were reviewed and updated for patients with complex needs.

Good

Are services effective?

(for example, treatment is effective)

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.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Patients requiring detoxification services for drug and alcohol were signposted to local provision.
- The practice's uptake for the cervical screening programme was 65%, which was highlighted as a significant negative variation from the CCG average of 87% and the national average of 81%. Staff told us that uptake for cervical screening was low owing to the ethnicity of the local population and a reluctance to attend and have a gynaecological examination. The practice were able to demonstrate that they regularly followed up patients who did not attend and they had taken action by enabling access to a female GP who spoke Hindi and would therefore be able to speak to females within the patient population and help to enable improvement to screening rates. The practice exception rate was 4% compared with the CCG average of 10% and the national average of 7%.

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 providing information leaflets 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. For example, the number of females aged between 50 and 70 who were screened for breast cancer in the last 36 months was 70% compared to the CCG average of 72% and the national average of 73%, and the number of people aged between 60 and 69 who were screened for bowel cancer in the last 30 months was 44% compared to the CCG average of 57% and the national average of 58%. There were systems to help 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.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages

Childhood immunisation rates for the vaccinations given were measured against an expected national coverage for vaccinations of 90%. There were four areas where childhood immunisations were measured and the practice was above the standard target in one of these areas, below the standard target in one of these areas and just below the target in the remaining two areas. For example, 95% of children aged 1 had the full course of recommended vaccines, 64% of children aged 2 had the Haemophilus influenzae type b and Meningitis C booster vaccine, 89% of children aged 2 had the Measles, Mumps and Rubella vaccine and 86% of children aged 2 had the pneumococcal conjugate booster vaccine.

These measures can be aggregated and scored out of 10. The practice scored 8.4 out of 10 and the national average was 9.1.

Childhood immunisation rates for the vaccinations given to five year olds were 89% for MMR Dose 1 compared to a CCG average of 93% and a national average of 94% and 89% for MMR Dose 2 compared with a CCG average of 85% and a national average of 88%.

Good

Are services effective?

(for example, treatment is effective)

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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.

All of the 51 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with five patients which included members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 78% of respondents said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 71% of respondents said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 87% of respondents said they had confidence and trust in the last GP they saw compared to the CCG and national average of 92%
- 68% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 85%.
- 94% of respondents 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%.
- 94% of respondents said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 100% of respondents said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 97% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 92% of respondents said they found the receptionists at the practice helpful compared with the CCG average and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the 51 comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. Staff spoken with were aware of the appropriate competencies when addressing children and young people.

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 and deemed comparable to local and national averages. For example:

- 69% of respondents said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 66% of respondents said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 78% and the national average of 82%.

Good

Are services caring?

- 92% of respondents said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 85%.
- 92% of respondents said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average and national average of 90%.
- 75% of respondents with a preferred GP stated that they would usually get to see or speak to that GP compared with the CCG average of 56% and the national average of 60%.

The practice were aware of this data and of their position in relation to CCG and national averages and had introduced a number of new systems to address issues highlighted. For example, the practice was in the process of developing into a larger partnership with three new GPs from another practice and a salaried GP one day each week, increasing the number of GPs available for consultations and access to female GP consultations.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- Information leaflets were available for people who did not have English as a first language, for example, information regarding the provision of cervical screening.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included the provision of the flu vaccine in their own home by the practice nurse. The practice achieved 100% for housebound patients who met the criteria for flu vaccine.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 20 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them and the practice asked the carer if they wanted them to contact one of three local support groups on their account. A leaflet was available for young carers.

Staff told us that if families had experienced bereavement, their usual GP wrote a condolence card to the family offering support. They also signposted the family to local bereavement counselling and put an alert on the patient record for family members so that staff were aware and could be sensitive.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to help to meet the needs of its registered patients. The practice was situated in an area of high deprivation, being the fifth most deprived borough within Kent. The population included a large Asian and Afro-Caribbean population and a higher than usual prevalence of patients with diabetes. For example, 7% of the patient population were identified as having been diagnosed with diabetes. The practice had engaged with the CCG on a pilot to help address the diabetes need at the practice and to improve patient outcomes. Staff told us that some of the patient population were reluctant to have a gynaecological examination and a female Hindi speaking GP had joined the practice giving female patients the opportunity to have a same sex appointment.

- The practice offered extended hours on a Monday evening until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing 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.
- Where children and vulnerable adults did not attend a telephone call was made to encourage an alternative appointment.
- The practice sent text message reminders of appointments and test results.
- The practice had introduced a cloud based telephone call system to increase access for patients.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Patients with little or no English attended the practice with an interpreter.
- The website provided educational information for patients regarding conditions and was translatable.
- The practice offered ultrasound scanning.
- Three partners from a separate practice had recently joined each working one day a week. One of the partners was female and provided patients with access to a female practitioner. The two practices work together to share resources and personnel and to provide patients with a wider range of services.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice was open between 8.30am until 1pm and from 2pm until 6.30pm from Monday to Friday. The telephone lines were open from 8am and during the lunch break period. Extended hours appointments were offered every Monday evening from 6.30pm until 8pm with a GP or a practice nurse. In addition to routine appointments that could be booked in advance, urgent on the day appointments were available for people that needed them. Appointments could be booked over the telephone, online or in person at the practice.

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.

- 77% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- 93% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 73%.
- 77% 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 70% and the national average of 76%.
- 93% of patients said their last appointment was convenient compared with the CCG and national average of 92%.
- 78% of patients described their experience of making an appointment as good compared with the CCG average of 68% and the national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 58% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 57% and the national average of 58%.

The practice had an action plan to address the areas where they scored lower than the CCG and national average for some areas of patient satisfaction.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

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. All telephone calls requesting a home visit or an emergency appointment were triaged by a GP.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, the process was displayed in the waiting room and on the practice website.

We looked at four complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way and there was openness and transparency in dealing with the complaints. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, where a patient was concerned that a call back request was not made, the practice established a system of courtesy calls to keep the patient informed when staff were busy and to ensure that all staff checked their diary at the end of the day for any return calls that needed to be made.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. This included succession planning and the development of the practice by forming a partnership with an additional three GPs and a salaried GP from a separate practice. The two practices now worked together to share resources and personnel and to provide patients with a wider range of services.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured 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 as did reception and administration staff.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. All letters and results were looked at by a GP on a daily basis and action taken as required. As a small practice, staff told us that they knew their registered patients well.
- Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice and to share good practice. Incidents and significant events were also discussed at these meetings and both clinical and non-clinical staff had clear awareness of incidents and significant events.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw documentary evidence of a structure that allowed for lessons to be learned and shared following significant events and complaints. The practice also shared these as presentations at learning events and raised quality alerts regarding secondary care where necessary.

Leadership and culture

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

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. From the sample of four documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

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

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

- The practice held and minuted a range of meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, by the partners and the management structure in the

Are services well-led?

Good

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

practice. Staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by the practice. For example, the practice manager had carried out a time and motion study of the work carried out by all staff at the practice to determine where to deploy staff in busy and quiet periods and to implement additional training where required or requested. The practice identified positive contribution by individual staff and acknowledged this.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients by analysis of the national GP patient survey and being aware of the practice position within the CCG.
- by developing the patient participation group (PPG) which was established in 2014 and had meetings annually.
- by looking at complaints and compliments received.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the staff team met and had a learning event once each month in the practice protected learning time; significant events and their outcomes were presented to colleagues to share learning; a talk had been planned at the practice regarding attention deficit hyperactivity disorder (ADHD) which is a group of behavioral symptoms that include inattentiveness, hyperactivity and impulsiveness as there were a significant number of children with the condition in the practice population; an afternoon of cooking was planned for patients, to look at low sugar low carbohydrate meals.