Dr Bathla and Partners- Soho Road Primary Care Centre

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.

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Summary of findings

Overall summary

Dr Bathla & Partners is situated at the Soho Road Primary Care Centre, Birmingham, and provides primary medical services to people in Handsworth and the surrounding areas. Access to a GP outside of practice hours is through the NHS 111 service. At the time of this inspection approximately 8200 patients were registered with Dr Bathla & Partners.

Practice staff comprised of three partners, which included two GPs and the practice manager, four other GPs, two trainee GPs, two practice nurses and several administration and reception personnel.

We spoke with 17 patients. They told us that they were happy to be registered at the surgery and expressed satisfaction at the services received.

As part of the inspection we also spoke with the Local Medical Committee which represents the GPs, the Clinical Commissioning Group which is the NHS body responsible for providing GP service, and the NHS Local Area Team, which monitors the quality of the services provided by the practice. They all told us that the practice worked with them to provide a local GP service for the population.

We found that the practice was safe, effective, caring, well led, and responsive. The practice had adequate arrangements to provide healthcare services for older people aged over 75; people with long-term conditions; mothers, babies, children and young people; the working age population and those recently retired (aged up to 74); people in vulnerable circumstances who may have poor access to primary care; and people experiencing a mental health problem.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe. We found that systems were in place to protect vulnerable adults and children who used the service from harm. Patients told us that they felt safe when they attended their appointments with doctors, nurses and other clinical professionals.

There were systems in place to make sure that practice staff learnt from events such as accidents and incidents, complaints and concerns. Staff knew how to respond in the event of a medical emergency. Recruitment checks were made on staff before they were employed which ensured they were fit and suitable to perform their duties.

Are services effective?

The service was effective. Care and treatment was delivered in line with current best practice standards. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of clinical care provided.

The practice proactively promoted health and well-being and the prevention of illness. Patients told us that GPs and other clinical staff listened to them and that they received appropriate care.

Clinical and other staff that worked at the practice were suitably qualified, trained and competent to carry out their roles.

Are services caring?

The service was caring. Patients told us that they were treated with dignity and respect and confidentiality was maintained. They also told us that staff were kind considerate and compassionate. Patients were consulted about their care and treatment and given information about the choice of the treatments available and supported to make decisions about their health.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice understood the different needs of the population and planned and delivered services to meet those needs. Appointments could be made in a number of ways with evening and Saturday morning appointments available. There was a system to review and look into any concerns or complaints people had raised and learn from these. Patients spoke positively about continuity of care provided by the GPs and other clinical staff.

Summary of findings

Are services well-led?

The service was well led. There were clear lines of management accountability and a defined governance structure. The practice had a business plan which set out opportunities to further develop clinical care. The vision and purpose of the service was shared by all staff. There was a system in place to identify and manage risks.

There was a patient participation group (PPG) which through active interaction with the GPs and practice staff had made useful contributions that had improved patients' experience of the service. Regular team meetings, partners meetings and staff away days facilitated a collective team approach to patient care.

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
The practice provided a range of services that managed the health of older people. The practice had a register that identified the needs of the older patient so their care and support could be given in a timely way. Care was reviewed regularly and included mental and physical health checks.

People with long-term conditions
We saw that patients with long term conditions were managed by a system of collaborative care that involved local coordination including follow up and referral to other services, such as secondary or acute care, when required.

Mothers, babies, children and young people
The practice offered services for mothers, babies, children and young people in conjunction with the NHS health visiting and midwifery teams. The service provided included checks on new babies as well as an immunisation programme for children up to 15 years.

The working-age population and those recently retired
There was flexible access to the surgery appointments that included on-line booking. Appointments for standard health checks were offered to eligible patients. The practice offered vaccinations to protect adults (and some children) at risk of flu and its complications.

People in vulnerable circumstances who may have poor access to primary care
The practice responded to the needs of patients with learning disabilities. Care plans reflected patients' needs and were reviewed annually. There was a service for homeless people. The practice was previously registered for the homeless enhanced service which ended in 2013. The practice however continued to support these patients.

The practice had good links with services such as the NHS, social services and housing. This helped them provide for the needs of people in vulnerable circumstances who may have poor access to primary care.

Summary of findings

People experiencing poor mental health

The practice had a system to identify and provide care for people experiencing mental health problems. Services were offered in conjunction with the NHS mental health team. Where appropriate patients were referred to specialist services.

Summary of findings

What people who use the service say

We spoke with 17 patients. They told us that they felt safe, received attentive and compassionate care and were happy with the service received. Staff had treated them with dignity and respect and maintained their privacy. GPs and other clinical staff had involved them in decision about their care and treatment and had asked for their consent to proceed with the treatment. Patients told us that they were able to obtain same day and forward appointments. Patients from an Asian background told us they found communication with practice staff easy because most of them spoke the main Asian languages.

39 patients completed a comment card which we asked them to do ahead of our inspection. All comments received were very positive about the services provided by the practice.

Patient surveys undertaken by the provider showed that overall people were very happy with the service. Improvements had been made as a result of the findings. The patient participation group was in the process of commissioning the latest survey which hoped to target about 400 patients.

Dr Bathla and Partners- Soho Road Primary Care Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP. The team also included a second CQC inspector, a practice manager and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Dr Bathla and Partners- Soho Road Primary Care Centre

Dr Bathla & Partners is situated at the Soho Road Primary Care Centre, Birmingham, and provides primary medical services to people in Handsworth and the surrounding areas. The practice has two GP partners, four other GPs, two trainee GPs, two practice nurses and several administration and reception personnel.

The out of hours service was contracted out to another provider which provided GP services when the surgery was closed.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Detailed findings

Before inspecting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We did this to identify any areas of risk that may be relevant to the five key questions. We carried out an announced inspection on 12 August 2014. The team inspected the surgery at 247-251 Soho Road, Handsworth.

During our inspection we spoke with a range of people who worked at the surgery such as GPs, the practice manager, practice nurses and reception staff. We spoke with patients and members of the Patient Participation Group (PPG). A PPG is a group of patients registered with the surgery who represent patients views. They work with the practice to make improvements in the service based on feedback from patients using the service.

Are services safe?

Our findings

Safe Track Record

There were arrangements for reporting safety incidents. The incident reporting policy clearly identified roles and responsibility and staff we spoke with were able to describe their role in the reporting process and knew their responsibility in identifying and acting on risks that affected patient care.

Staff were made aware of key risks that affected patient care by regular discussions on risks that arose out of safety incidents. We saw minutes of meetings which demonstrated that all areas of risk were highlighted and addressed. For example, significant event analysis, complaints, medical alerts and issues raised through the patient participation group. Action points for improvements were agreed during these meetings. We saw that the practice had reviewed its working arrangements against a NHS England safety alert about making sure test results for ECG were linked to the correct patient.

The practice manager ensured each safety related issue was followed through in a timely way. For example, we saw that complaints and significant events had been analysed annually with learning points presented to the practice team which ensured all staff were made aware of key issues that affected patient care and the actions taken to prevent future occurrences.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events.

When things went wrong, the practice investigated what happened and learnt from the findings. We saw that the practice conducted a significant event analysis(SEA) after each safety incident and implemented actions to prevent reoccurrence. An SEA is a technique to reflect on and learn from individual incidents to improve quality of care overall. We saw evidence that actions arising from SEAs were reviewed every three months to ensure these were implemented effectively. All staff we spoke with confirmed SEAs were discussed at clinical practice meetings and we saw evidence to support this. The practice manager showed us an example where as a result of an SEA, the process for issuing repeat prescriptions had been changed.

There was a safety alert protocol and procedure. This ensured any patient safety issues, important public health messages and other safety critical information and guidance relevant to patient care were cascaded in a timely way to all concerned staff. The practice manager was the responsible officer to receive, disseminate and check that action had been taken as a result of any alert received, and we saw electronic records of alerts received and cascaded.

The practice operated a policy of openness and transparency when things went wrong. The 'Being Open' policy allowed practice staff to work with the patient and other involved health care professionals and help reduce the impact, stress and worry for all concerned following a safety incident.

Reliable safety systems and processes including safeguarding

Policy and procedural guidance was up-to-date, to ensure safety of the services provided. Recruitment checks were made on staff before they were employed which ensured they were fit and suitable to perform their duties. Where required, the practice had undertaken the necessary checks required to establish the staff member's right to work in the UK.

Appropriate checks were carried out when the practice recruited new staff. Clear and up-to-date recruitment policies and procedures were in place. We reviewed the personal files of two newly recruited staff and one long serving member which showed that appropriate procedures had been followed.

On the files we reviewed, we saw that pre-employment checks had been undertaken, with personal and professional references obtained. We also saw, for clinical staff, that Disclosure and Barring Service (DBS) checks had been obtained. The DBS check is a process of gathering information about an applicant's possible criminal activity and helps determine their suitability to work with vulnerable people. For those roles where DBS checks were not required the practice had undertaken proportionate risk assessments.

All patient information was stored electronically and we saw that staff had individual secure access to the information database. Arrangements were in place for emergency situations with back-up systems available. IT servers were housed in a separate, temperature controlled office with appropriate security arrangements in place.

Are services safe?

The practice shared building space with a number of other health care providers and we saw that security arrangements were in place to monitor access throughout the day, with closed circuit television cameras and security guards on site.

The practice had clear and comprehensive safeguarding policy and procedures for child and adult safeguarding matters. Information included a step-by-step flow chart for staff, which identified possible signs of abuse and described what action to take. Contact details for the local authority safeguarding teams and other agencies were clearly noted and freely available for staff should they need to make a referral or contact other health care agencies. The policy and information was regularly reviewed and updated, most recently in April 2014.

The senior partner had lead responsibility for safeguarding across the practice and we saw that all established GPs had received safeguarding training, with others awaiting formal training. All other staff at the practice had received safeguarding training appropriate to their role.

We saw that the practice held regular briefings and updates on safeguarding awareness. The safeguarding lead conducted three monthly case reviews.

There was a chaperone policy. A chaperone is a person who acts as a witness for a patient and a clinician during a personal medical examination. Staff we spoke with were aware of the policy and had received appropriate training. On the day of our inspection we did not see anyone requesting a chaperone.

Monitoring safety and responding to risk

There was a range of information available to patients. We reviewed a sample of the information available and saw that these provided information on who to contact in the event of physical health emergencies or mental health problems either during or outside of practice opening times.

Staff knew how to respond in an emergency. The practice had an emergency call icon on all computer screens. In the event of an emergency this icon was activated. This alerted staff in other parts of the building to the emergency and requested them to respond to it. Staff at the practice had received training in medical emergencies such as anaphylaxis and basic life support skills.

There was sufficient and up-to-date emergency equipment available for use by all trained and competent staff. Routine checks of this equipment were undertaken by a designated GP. Emergency medicines were available and were routinely audited to ensure all items were in date and fit for use.

Medicines management

We looked at the arrangements for managing medicines. The practice had a medicines management policy and a repeat prescription policy. The senior partner was the lead GP for medicines management. These policies covered prescribing medicines, repeat prescriptions, reviewing prescribed medicines and prescription authorisation processes. Staff we spoke with were aware of the safe procedures for prescribing of medicines and able to demonstrate their understanding of the policies.

The practice had arrangements that made sure temperature sensitive vaccines were transported and stored at the correct temperature. We saw records of temperature checks to ensure the vaccine storage fridge remained within acceptable limits for vaccine safety and potency.

The practice had in 2013 audited its repeat prescription process. A comparison with the 2012 audit had shown encouraging outcomes with improved prescribing patterns for inhalers for patients with breathing difficulties and antibiotics.

Prescription pads were held securely. Serial numbers of the pads were recorded on receipt for security and on issue to the GPs to ensure their accountability.

Cleanliness and infection control

Patients were protected from the risk of infection because appropriate guidance had been followed.

There was a policy for infection control and staff we spoke with were aware of the requirements of this policy. Staff told us that they had attended infection control training and we saw records that confirmed this. The practice manager and an infection control lead nurse were named as joint leads for infection control. An external infection control audit had recently been done by the clinical commissioning group and the practice had received positive verbal feedback but awaited the report that was due shortly.

Are services safe?

Patients told us that they found the waiting room and the consulting rooms clean. There was a daily cleaning schedule for the premises. The practice manager told us that they visually checked the building for cleanliness every day. There were hand washing facilities available with antibacterial hand wash and hand gel. There were posters above each hand wash basin which provided guidance to staff on safe hand washing techniques. Appropriate personal protective equipment such as examination gloves, plastic protective aprons and disposable cover sheets for examination couches were available in patient consultation rooms and treatment rooms to minimise the risk of infection.

In the consultation rooms and treatment rooms we inspected we saw that correct colour coded bin liners had been used in waste bins which were foot operated to minimise the spread of infection. All cleaning materials and chemicals were securely stored and control of cleaning and other substances hazardous to health (CoSHH) was managed adequately to ensure their safe use. We saw evidence of a cleaning audit which showed cleaning practices were being followed.

The practice undertook Legionella water safety checks. Water temperature checks were undertaken by the estates management team which ensured the safety of water used in the surgery. Water taps in areas that were used less frequently were regularly flushed.

There were arrangements in place for the safe disposal of clinical and non-clinical waste, including sharps such as needles and disposable instruments. Waste was regularly collected by a waste disposal contractor who together with the practice staff worked to a collection/disposal of waste policy which had been agreed with the practice in accordance with national guidance.

Staffing and recruitment

We saw that staffing levels were set based on the number of patients registered with the practice. The set levels were then reviewed on a weekly basis and adjusted based on demand. On the day we inspected we found that there were adequate numbers of GPs and other clinical staff available for patient consultations. The practice had undertaken a review of the service provided on a Thursday and had made additional provisions to open on Thursday afternoons which was previously not available.

The practice had systems in place to check and monitor the on-going registration arrangements for all professional staff. The practice manager held a list of checks that had been undertaken on registration arrangements and copies of appropriate registration certificates had been scanned for retention.

Dealing with Emergencies

The practice had a comprehensive business continuity plan in place. The plan included arrangements for dealing with a range of minor and major incidents. The practice had regular fire drill evacuations and had worked with other occupiers of the building to monitor and manage the potential impact of disruptions to electrical and IT systems.

Equipment

The equipment used in the practice was maintained, serviced and safe to use. Equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) had been serviced and calibrated as appropriate.

Portable electrical equipment used in the surgery was routinely portable appliance tested (PAT) and we saw evidence of this check. Equipment used in patient examinations and minor surgery were single use items and were disposed after use. We checked a sample of single use equipment and found that they were in secure sterile packs and in date. If equipment became faulty or required replacement, these were referred to the practice manager who arranged for their replacement. Equipment such as the computer based record system were password protected and backed up to prevent data loss.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patient care and treatment needs were assessed and delivered in line with current legislation, standards and guidance. There was a systematic approach to identifying relevant legislation, latest best practice and evidence-based guidelines and standards. Clinical staff had access to policies, procedures and clinical guidelines electronically as well through a hard copy folder. Two nominated GPs reviewed progress in implementing the guidance received annually.

The practice undertook minor surgery. A GP with special interest in minor surgery carried out the surgery. There were procedures to obtain informed consent. Patients told us that the GP usually discussed the benefits and drawbacks of the surgical procedure and, where possible, gave them time to consider alternative options before they obtained their consent to go ahead. Clinical staff we spoke with were aware of the requirements of the Mental Capacity Act 2005.

Patients told us that the GPs and nurses listened to them and that they had received care and treatment appropriate to their needs.

Management, monitoring and improving outcomes for people

Complete, accurate and timely performance information, including patient outcomes, was available to staff and the public, which included reports on clinical audit and the Quality and Outcomes Framework (QOF). QOF is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care. The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure.

The GPs told us that they all undertook clinical audit as part of their revalidation process with the General Medical Council. There were also other clinical audits undertaken by the GP registrars and nurses. Clinical audit is a quality improvement process which seeks to improve patient care through a systematic review of the care provided and making changes to improve it.

The registered manager showed us a number of clinical audits that had resulted in improved patient care. For example, infection control following minor surgery, the safety of the use of a specific anti-inflammatory medicine and antibiotic prescribing.

The practice had re audited to check if the improvements made had been effective and had been sustained. For example the diabetic audit had enabled the practice to shape the future provision of diabetic care. In conjunction with the local clinical commissioning group, the practice now had a specialist team which included a diabetes specialist and other staff to provide care and support to the diabetic patient.

The QOF was last reviewed in April 2014, and we saw that the practice had performed in accordance with the targets set.

Patients told us that their health needs were managed well. They told us that where necessary they have had their follow up monitoring within the timeframe and the GPs and other clinical staff they saw had talked through with them any lifestyle changes that may give them a better health outcome.

Effective Staffing, equipment and facilities

The staff we spoke with told us they were supported well by the GPs, the practice manager and the nursing team. They told us that they were given opportunities to maintain and develop their role through learning such as online learning and in-house training. Patients we spoke with told us they found the staff skilled, knowledgeable and approachable.

We reviewed the arrangements the practice had in place for the effective induction and ongoing support and development of staff. There were effective induction programmes for new staff. We saw the practice had recently reviewed and enhanced the induction arrangements for new starters. We saw evidence of a comprehensive induction plan which was linked to an initial learning needs assessment.

On-going staff support was provided by three monthly personal support meetings. This meant that a continuous support and development package could be designed to meet individual needs for each staff member. Staff we spoke with confirmed this arrangement.

Staff training was reviewed at annual appraisal, with learning and development needs identified and agreed for

Are services effective?

(for example, treatment is effective)

the year ahead. The practice manager showed us an overall training plan which covered professional and other staff. This enabled the practice to monitor the training needs of its staff and book courses where necessary.

There were appropriate systems in place to manage the performance of staff, with policy and procedures in place to deal with poor performance or inappropriate conduct and behaviour if required.

Clinical staff at the practice ensured they developed their knowledge and skills through continuous professional development. For GPs this included an annual appraisal and revalidation which happened every five years. Revalidation is a process by which the GPs demonstrate that they are meeting the standards set by the General Medical Council. Practice nurses completed a similar process set by the Nursing and Midwifery Council and renewed their license to practice annually.

The practice operated from a purpose built facility acquired in 2010. Equipment available and facilities within the practice were sufficient to meet the needs of patients. There was adequate access both to the surgery and to toilet facilities for disabled patients. The consultation rooms and treatment areas were appropriate to the needs of the patient and had the required levels of equipment. The estates management team had an on-going maintenance programme for the buildings and facilities.

Working with other services

There was effective communication, information sharing and decision making about a person's care across all of the services involved. We saw evidence of working arrangements with a range of services such as the community nursing team, health visiting team, the local authority, hospital consultants and other local and voluntary groups. We spoke with two health visitors and a member of the community nursing team. They told us that the practice and their teams worked closely to respond to patient needs.

The practice worked with the out-of-hours service including the community nursing services so that people who needed end-of-life care had continuity of care. Multiple linked services such as podiatry, smoking cessation, sexual health and family planning were all accessible through the practice.

Patients told us that they could ask for their blood test or other investigation results by telephoning the surgery. They told us that the practice would contact them should the results indicate further treatment and support was needed following the tests. Reception staff we spoke with told us that if a patient enquired about their test results on the phone, then they would be referred to a clinical professional for a response.

Health, promotion and prevention

We found a varied selection of health promotion and prevention leaflets in the waiting areas and corridors of the practice. Leaflets included information/advice on smoking cessation, family planning, childhood illness, flu vaccination, mental wellbeing, managing stress and bereavement support.

The practice proactively identified people who may need on-going support. This included people who needed support to manage their diabetes, high blood pressure, chronic obstructive pulmonary disease (COPD) or mental health issues.

Newly registered patients were offered a routine check to review and note details of their medical and family histories; medications; social factors, including occupation and lifestyle; and measurements of risk factors. In addition they were also offered additional tests and advice as appropriate. For example chlamydia screening, smear test, smoking cessation advice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients and those close to them were treated with respect. Patients told us that staff were kind, considerate and compassionate, and that the practice staff treated them with respect and dignity at all times. They told us that the GPs and all staff at the practice listened to them and gave them time to explain their needs. Staff had a person-centred approach and respected people's individual preferences, habits, culture, faith and background.

We spent some time at the reception. We saw that reception staff treated patients with dignity and respect, and listened to their needs before they made any appointments. Confidentiality was respected at all times. We saw patients talk in confidence with reception staff and, where applicable, patients were offered the opportunity to discuss personal details in private consultation rooms.

Information provided by patients on comment cards and left for us showed that patients were very appreciative of the way clinical and administrative staff looked after their needs.

Involvement in decisions and consent

Patients told us that the GPs and other clinical staff always engaged and involved them in their care and treatment. They told us that they were given appropriate information and support which helped them to make decisions. For example we saw a variety of disease specific information in various languages that clinicians gave to patients to help them make informed decisions about their care and treatment.

The registered manager told us that in the event a patient lacked capacity to make decisions about their health and care needs, then the GP or other clinical professional would liaise with the patient's representative and or their carer and undertake best interest decisions under the Mental Capacity Act 2005, and agree appropriate treatment options. Further support was available from the psychiatrist from the local NHS trust. Clinical staff we spoke with were aware of the requirements of the Mental Capacity Act 2005. We saw training records that showed all clinical staff had received training in mental health.

Staff showed effective communication skills. Staff used different method so patients' communication needs were met in an appropriate and respectful way. The practice had a large Asian population and other patients from diverse ethnic and religious background. Reception staff and the doctors at the surgery spoke a range of languages including the main Asian languages and French. The practice had access to an interpreting service. We saw a receptionist recognise the need for an interpreter and arrange one for a patient when they made a future appointment to consult with a GP.

There was a hearing loop induction system in place to help people with hearing problems. The practice manager told us that the patient participation group (PPG) was working with the surgery to implement MAKATON, which is a language programme that uses signs and symbols to help patients who experience hearing difficulties to communicate.

Where possible and relevant staff posted a note on the patient's computer record which alerted practice staff to the specific communication issue and other needs of the patient so they used appropriate methods when communicating with them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to design services. We saw evidence of regular meetings with the local commissioning group to discuss service provision.

The patient participation group (PPG) took an active role in suggesting improvements to the service provided. A PPG is a group of patients registered with the surgery who represent patients views. They work with the practice to make improvements in the service based on feedback from patients using the service. We spoke with three members of the PPG including the chairperson. The PPG usually met monthly with the practice manager in attendance. The practice had responded well to their suggestions which had resulted in improvements to the appointment system including the introduction of an on line booking system. The PPG was working currently to improve car parking facilities. Future plans included the commissioning of a patient survey in September which would involve the distribution of 400 questionnaires.

There were clinics to manage patients with chronic obstructive pulmonary disease (COPD), asthma, heart disease, diabetes, and those that were on blood thinning medication. There were also clinics for child health, family planning and minor surgery.

The practice was situated in a socially deprived area with a very high Asian and other ethnic population. The practice offered a female doctor choice for those patients that preferred it. They also employed staff that lived locally so patients' spiritual, ethnic and cultural needs were understood and considered alongside their health needs.

The practice liaised with other agencies to make sure patients' needs continued to be met. For example the practice shared information with the community services and out of hours service provider on people that need end of life care so their needs continued to be met uninterrupted when the surgery was closed.

There were arrangements to refer or transfer patients to another service so patients' needs were met at the right time. The practice had referral criteria that helped clinicians to make timely referrals after relevant investigations and tests had been performed. Patients told us that they had not experienced any problems in accessing secondary care when referred to these services. The practice manager told us that patients could use 'Choose and Book' to access secondary care services which gave them a choice of the time and place for their appointments. 'Choose and Book' provides patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

Access to the service

We spent time with reception staff. They showed us the appointment system that the practice used. The practice was open six mornings and five evenings per week. The out of hours service was contracted out and provided GP services when the surgery was closed.

Patients made appointments for consultation by telephone, in person or online. Patients told us that they could obtain a same day appointment but often this meant seeing a GP other than their own. The receptionist explained that forward appointments were available up to two weeks in advance and patients that wanted to see a specific GP made use of this facility.

The practice had a protocol for patients to request and obtain repeat prescriptions. Patients could request these in person, by post or online. All requests received before 12pm were processed and made available to the GP for review and authorisation prior to issue to the patient.

There was a practice leaflet that gave accurate and up-to-date information about the services provided. The practice website also gave similar information. However at the time of writing this report we found the practice website had been taken off line for maintenance work.

Concerns and complaints

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

Patients we spoke with knew how to raise a concern or make a complaint. Information about how to make a complaint was available on the practice notice board, in the practice leaflet and on the practice website. Patients we spoke with expressed no concerns about the practice or staff but told us that they would raise any concerns they had with the GP in the first instance and expressed confidence that it would be resolved appropriately.

Are services responsive to people's needs?

(for example, to feedback?)

Any complaints received were responded to as per the policy. The practice reviewed complaints received annually. We saw the review for the year ended 31 March 2014 and noted that improvements had been made to ensure privacy during consultation and when a particular intimate test was performed. Staff told us that they were aware and informed of the outcomes of complaints during staff meetings if they were relevant to their role.

Are services well-led?

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

Our findings

Leadership and culture

The practice had a business plan which set out opportunities to further develop clinical care. This was underpinned by the practice management structure, led by the registered manager and the practice manager, which ensured both clinical and non-clinical staff understood the key concepts of compassion, dignity, respect and equality when they provided care.

Staff told us that they felt supported and valued in their respective roles. They knew who to go to with any issues or concerns they may have. They told us they were listened to and felt included in decisions about the quality of the service provided.

There was an understanding of the current and future leadership needs of the organisation. We saw evidence of on-going leadership development and succession planning for key management positions at the practice.

Governance arrangements

The practice had a clinical governance structure with identified roles and responsibilities for each GP. For example a GP partner was responsible for clinical leadership. This arrangement made sure practice staff were clear about their responsibilities and understood who to approach if they needed further advice or guidance. Staff we spoke with knew who their manager was and told us that they were supported well by their manager and other colleagues.

The practice was an approved teaching practice to train new GPs and the registered manager told us that that a new GP trainee had recently commenced their training at the practice. We checked and found that there were sufficient governance arrangements to ensure adequate supervision and support for GP trainees.

There were regular practice and partner meetings to discuss improvements and issues relating to the running of the service. GPs from the practice attended local clinical groups that met regularly and reviewed clinical issues.

Systems to monitor and improve quality and improvement

The practice had systems to check the quality care that patients received. The importance of high quality data and information was recognised by all practice staff. GPs and other clinical staff took individual responsibility to audit clinical care under the leadership of a lead clinician. The practice manager regularly reviewed the Quality and Outcomes Framework (QOF) monitoring reports and agreed actions to improve performance against targets set if needed.

The practice analysed comparative practice data from the CCG to help them address any areas where improvements could be made. For example, we saw evidence of improvements made to prescribing patterns of a certain medicine a result of monitoring data that indicated the practice was not achieving the right outcomes for patients.

Patient experience and involvement

A full and diverse range of patients' views were encouraged, heard and acted upon. The practice had a patient participation group (PPG), which met monthly. We spoke with a number of members of the group, including the chair person. They told us that their group was supported well by the GPs and practice staff. Their current priority was to help commission the latest patient survey which was due in September 2014.

Staff engagement and involvement

We saw notes of regular staff meetings which discussed a range of practice and staff issues. The notes we saw showed that staff were consulted and involved in the smooth running of the practice. The practice had a whistleblowing policy which allowed staff to report suspected wrongdoing at the practice without being penalised for doing so.

The practice sought and acted on feedback from patients and the public. This included analysis of complaints and comments received, acting on the findings, and acting on surveys commissioned by the PPG. We saw evidence of improvements made as result of complaint analysis and patient surveys. For example we saw that action had been taken to improve access to appointments on the practice's website as well as extended surgery hours following analysis of patient satisfaction reports.

Learning and improvement

The practice had a business plan, which outlined high-level development opportunities. The practice may wish to consider developing a more detailed plan identifying someone with responsibility for taking the work forward.

The individual staff files we reviewed contained personal objectives for the year ahead.

Are services well-led?

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

The practice had a policy in place to respect the 'protected time' education initiative and this was implemented to enable staff to take advantage of learning and development opportunities.

The practice manager and assistant manager led on the performance review and improvement across the practice. Practice meetings discussed performance and identified successes and areas for development opportunity.

The practice had a comprehensive selection of policy documents relating to risk assessment and management across operational, clinical and staffing areas.

The practice identified that future developments included consideration of the identification of key performance indicators, which could be shared with all staff routinely at staff meetings.

Identification and management of risk

The practice had management systems to review potential and actual risks to the delivery of safe patient care. We saw evidence of risk assessments related to environmental issues, patient safety, infection control, ensuring vulnerable patients were protected, the management of medicines, staff safety, record keeping, health and safety and managing emergency situations.

The practice had a business continuity plan which gave instructions on how to maintain essential services in the event of sudden failure of service.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

There was a named accountable GP to look after the needs of patients aged 75 and over. The practice maintained a register of patients aged 75 and over so their health needs could be easily reviewed and attended to. Currently the practice looked after approximately 317 patients aged 75 and over.

Older people were offered regular health assessments which included mental and physical health checks. When patients attended for their health checks the practice acted opportunistically and offered them their annual flu vaccinations and reviewed their other health needs. The practice regularly reviewed any medicines that they were prescribed. Housebound older patients were visited at home if needed. This helped to ensure patients received the care treatment and support they needed.

We saw evidence of regular multidisciplinary team meetings where care professionals discussed patients' individual care needs and support arrangements. These meetings included discussions about end of life care for those who needed it and discussions with the out of hours service provider about their care needs so there was continuity of care.

The practice had commenced a review of unplanned admissions and accident and emergency attendances and intended to complete and act on this by September 2014.

The practice worked with the voluntary sector to provide care and support for patients suffering with dementia and their carers. Support was provided by the Dementia Information and Support for Cares (DISC) network.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had clinics to manage chronic obstructive pulmonary disease (COPD), asthma, heart disease prevention, blood pressure, diabetes, and those patients who were on blood thinning medication.

The practice operated a recall system to remind patients to attend their annual health review. A set proforma was used for this review which ensured all patients' needs had been taken account of when any care and support was planned. The practice manager told us that 90% of eligible patients attended their annual review.

The management of diabetes was led by a GP with special interest in diabetes. This GP and a nurse had attended a specialist diabetes training given by Warwick University. The practice manager told us that the COPD nurse had been trained in advanced management of COPD and contributed to effective COPD management.

There were effective links with community nurses and Macmillan nurses to plan coordinate and deliver effective palliative care. The practice worked with the out of hours service so that people that needed end of life care experienced continuity of care. This helped ensure patients received co-ordinated care which met their individual needs.

Where necessary patients were referred to community based clinics such as diabetic and respiratory clinics which offered them support and gave them the opportunity to meet other patients with similar conditions and learn together on how to manage their long term condition.

There was adequate access both to the surgery and to toilet facilities for disabled patients.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice in conjunction with the NHS health visiting and midwifery teams provided care for mothers, babies and children. There was a range of information available for new and expectant mothers, and on the care of a new baby.

The practice made checks on new babies and provided an immunisation programme for children up to 15 years. Eligible children and pregnant women were offered flu immunisation. Young people were offered the opportunity to see a GP on their own. This allowed them to discuss confidential personal issues without the presence of a guardian. There was a contraceptive implant service for young people and others.

Support was available for new mothers with emotional issues via a local counselling service which the practice could refer to if necessary.

The practice had a lead for safeguarding and all clinical staff had received the recommended level of training for safeguarding, child protection and obtaining consent for children and young people. The practice worked closely with the health visiting service and regularly reviewed children that needed protection.

For pregnant patients much of the care was provided in conjunction with the midwife. The practice offered priority appointments for pregnant patients and children which ensured quick access to a GP.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered appointments for consultation by telephone, in person or online. Patients told us that they could obtain a same day appointment but often this meant seeing a GP other than their own. Advance appointments for up to two weeks could be booked and this gave the opportunity for patients to see a GP of their choice. The practice also offered emergency access to a GP through a telephone triage system.

There were arrangements in place so that patients could access services at a time convenient to them. Repeat prescriptions could be requested in person, by post or online. There were walk-in clinics for phlebotomy (taking of blood for tests), family planning and 'Healthy Minds' which is a counselling service. Patients that needed referral to another NHS facility were offered 'Choose and Book' which gave them a choice of the time and place for their appointments.

The practice offered NHS health checks and flu vaccinations to eligible patients. The NHS health check included a vascular risk assessment for cardio vascular disease (CVD) which is a disease of the heart or blood vessels and helped identify and treat this early.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice was previously registered for the homeless enhanced service which ended in 2013. The practice however continued to support these patients. Practice staff told us that people in vulnerable circumstances could access their services in the same way as their registered patients.

In conjunction with the NHS learning disability team, the practice offered support and care for patients with a learning disability that lived in the community. The practice had a learning disability register that identified the specific needs of this group. These patients were offered an annual health review, and their carers were invited to attend with the patient's consent. The practice used different methods to communicate and was currently considering MAKATON, which is a language programme that uses signs and symbols to help patients with hearing difficulties to communicate.

The practice offered extended consultation times of 40 minute duration so patients were given time to discuss all their health and social needs and agree support and care. Where necessary the practice worked with other local services such as the NHS, social services and housing to address patients' health and social care needs.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice manager told us that they worked closely with the local NHS mental health team. If needed, patients were referred to this team or the Improving Access to Psychological Service (IAPT) for further assessment, treatment and care. The practice offered single point access for emergency referrals to the local NHS mental health team.

The practice had a lead for mental health care. The practice nurse was trained in the administration of long acting medication called DEPO. There was a register of patients with mental health needs and the practice used this register to offer targeted care such as the annual mental health review, and administer long acting medication to help manage their mental health.

There was information available about depression and mental illnesses in patient waiting areas. Patients could access support through 'Healthy Minds' which is a local counselling service. This provided the patient an opportunity to recognise and seek help and support early.