

Shifa Surgery

Quality Report

Bangor Street Health and Community Centre
Blackburn
Blackburn with Darwen
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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?

Requires improvement 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Shifa Surgery on 20 July 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. We saw that learning from significant events was communicated with staff effectively and staff were aware of any changes implemented as a result in order to minimise the risk of the event being repeated.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients had rated the practice in line with others for many aspects of care. Patient feedback we received as

part of the inspection process indicated patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- While some patients expressed concerns regarding appointment access, we saw that the practice was taking action to address these concerns and there was improved 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 strongly supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour.

The areas where the provider should make improvement are:

Summary of findings

- An action plan following an infection control audit should be produced to document that all required actions have been completed in a timely manner.
- Clinician's professional registration status should be consistently recorded in order to document that the check has been carried out.
- Work to validate the carers list should be completed and alerts on the electronic records used to facilitate and maximise access to appropriate support services.
- Continued work should be undertaken and monitored to address patient concerns around access to appointments.

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?

The practice is rated as good for providing safe services.

Good



- 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 thorough action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received support, truthful information, and an appropriate 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.
- The premises were clean and tidy, and an infection prevention and control audit had been carried out earlier in the year. We noted that while issues raised as part of this audit had been addressed, the completion of actions had not been documented.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The lead GP had also devised a practical questionnaire for the staff in order to support and consolidate this learning.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed patient outcomes were variable compared to the national average.
- Staff were aware of current evidence based guidance. Any updated guidance was discussed at meetings and practice protocols updated accordingly.
- Clinical audits demonstrated quality improvement and were driven by the specific needs of the population the practice served.
- Staff had the skills and knowledge to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff. We saw that targets identified for staff were linked to the practice's strategy and needs with regards to quality improvement and promoting better patient outcomes.
- 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. External stakeholders and patient's relatives praised the practice for the high quality end of life care offered to patients.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice in line with others for several aspects of care.
- Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients praised the clinicians for the personalised, high quality care and treatment offered.
- Information for patients about the services was available and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice was in the process of validating and updating its carers register.
- The practice had designed a sympathy card which was sent to families at times of bereavement.

Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services.

Requires improvement



- The practice understood its population profile and had used this understanding to meet the needs of its 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.
- Results from the GP patient survey suggested patients were dissatisfied with access to appointments, with the practice's scores placing it substantially lower than others for many areas relating to appointment availability. However, the three patients we spoke with during our visit 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 devised an action plan to address

Summary of findings

patient concerns, with actions being implemented in a timely manner in order to improve access. For example, an additional telephone line was being diverted to reception at busy times to facilitate telephone access.

- 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 the examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had 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.
- The provider 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 told us they felt valued and recognised the positive impact the current provider had had since taking over the service as sole provider in March 2016.

Good



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 is rated as good for the care of older people.

Good



- 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.
- 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.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- 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

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

Good



- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance against the Quality and Outcomes Framework for long term conditions was variable when compared with local and national averages.
- 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

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

- We saw there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice had implemented actions to improve the uptake of cervical screening.
- 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.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had produced a bespoke card which it sent out to families congratulating them on the arrival of a new child and signposting them to relevant health services in order to promote uptake of the relevant checks.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Good



Working age people (including those recently retired and students)

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 appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the

Good



Summary of findings

needs for this age group. It had made increased efforts to promote these services in response to patient feedback around access to appointments, in an effort to raise patient awareness of alternatives available.

People whose circumstances may make them vulnerable

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 those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. 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.

Good



People experiencing poor mental health (including people with dementia)

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.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 78% compared to the CCG average of 87% and national average of 84%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- 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.

Good



Summary of findings

- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results suggested the practice was performing below local and national averages, although we were given more positive feedback from patients who engaged with us as part of our inspection process. A total of 384 survey forms were distributed and 85 were returned. This represented a completion rate of 22% and was approximately 1.5% of the practice's patient list.

- 67% of patients described the overall experience of this GP practice as good compared with the CCG average of 86% and the national average of 85%.
- 32% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 55% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 79% and national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 19 comment cards which were all strongly positive about the standard of care received. Many of the cards named specific clinicians to praise the personalised care and treatment they offered. In addition to making positive comments, three of the cards also referenced some frustrations with accessing appointments. However, we also noted that two cards specifically praised the practice for the access to appointments it offered, stating that they were always able to get an appointment either on the day of request, or the following day.

We spoke with three patients during the inspection, all of whom were also members of the practice's patient participation group. All three patients said they were highly satisfied with the care they received and thought staff were approachable, committed and caring. The GPs were described as personable and patients felt their manner put patients at ease. All felt that the practice had responded positively to patient feedback regarding access and had made improvements the appointment system as a result. They all felt that appointments were available when needed.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- An action plan following an infection control audit should be produced to document that all required actions have been completed in a timely manner.
- Clinician's professional registration status should be consistently recorded in order to document that the check has been carried out.
- Work to validate the carers list should be completed and alerts on the electronic records used to facilitate and maximise access to appropriate support services.
- Continued work should be undertaken and monitored to address patient concerns around access to appointments.

Shifa Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist adviser.

Background to Shifa Surgery

Shifa Surgery (Bangor Street Health and Community Centre, Blackburn, BB1 6DY) is located in a purpose built, single story premises in a residential area of Blackburn, close to the town centre. The premises has ample parking spaces and ramped access to facilitate entry to the building for people experiencing difficulties with mobility.

The practice delivers primary medical services to a patient population of approximately 5440 people via a general medical services (GMS) contract with NHS England. The practice is part of the NHS Blackburn with Darwen Clinical Commissioning Group (CCG). The current single-handed GP provider assumed sole control of the practice when the previous senior GP partner left in March 2016.

The average life expectancy of the practice population is slightly below the national averages (77 years for males and 81 years for females, compared to 79 and 83 years respectively nationally).

The practice has a higher proportion of younger patients than the average practice both locally and nationally. For example, 31% of the practice population are aged under 18 years, compared to the local average of 27% and national average of 21%. Conversely, the practice caters for a lower proportion of older patients; for example just 6% are aged over 65 compared to the local average of 14% and national average of 17%.

Information published by Public Health England estimates that 67% of the practice's patient cohort is of Asian ethnic background.

Information also published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice is staffed by the GP provider (male) along with a long term locum GP (male). In addition the practice employs two advanced nurse practitioners, a practice nurse and a health care assistant. Clinical staff are supported by a practice manager and a team of six administrative and reception staff.

The practice is a teaching and training practice, taking medical students as well as registrars.

The practice is open between 8am and 6.30pm each weekday apart from Monday, when extended hours appointments are offered until 7.30 in the evening. Surgeries are offered between 8.30am and 12.00 each morning, and between 1.30pm and 4.30pm each afternoon apart from Friday, with Monday evening's extended hours' appointments running between 6.30 and 7.30pm.

Outside normal surgery hours, patients are advised to contact the out of hour's service by dialling 111, offered locally by the provider East Lancashire Medical Services.

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

Detailed findings

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 such as the clinical commissioning group to share what they knew. We carried out an announced visit on 20 July 2017. During our visit we:

- Spoke with a range of staff including the lead GP, the long term locum GP, an FY2 trainee GP, one of the advanced nurse practitioners, the practice nurse, practice manager and members of the administrative staff. We also spoke with patients who used the service.
- Observed how staff interacted with patients.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- 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.

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 or lead GP 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 the sample of nine 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 support, truthful information, an appropriate 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 that a culture of learning and continuous improvement was comprehensively embedded into practice. We saw that positive outcomes were documented as significant events, as well as events where things had gone wrong, in order to maximise the implementation of best practice.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. Staff we spoke to were able to recount in detail recent significant events that had been discussed in team meetings to disseminate learning. For example, following a patient's admission to hospital, the practice protocol had been reviewed and updated around the prescribing of a particular kind of medication in order to minimise the chances of the circumstances leading to the admission being repeated.
- The practice also monitored trends in significant events and evaluated any action taken.

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. The GP provider was lead member of staff for safeguarding. We were told that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. We saw that safeguarding was an agenda item at clinical team meetings in order to facilitate effective information sharing around vulnerable patients.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and advanced nurse practitioners were trained to child protection or child safeguarding level three. All other staff including the nursing staff were trained to level two. The lead GP had also devised a safeguarding questionnaire for staff based around hypothetical scenarios in order to consolidate staff understanding of the issues and to supplement the formal training completed.
- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. 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

Are services safe?

undertaken and we saw evidence that action was taken to address any improvements identified as a result. However, we noted that while actions had been completed, these had not consistently been documented as such meaning there was not always a thorough audit trail of what had been done.

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. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed three 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, and the appropriate checks through the DBS.

While we saw that clinicians were registered with the appropriate professional body as required, it was not consistently documented that this had been checked as part of the recruitment process. The practice manager informed us that these checks had been carried out, however they had not been recorded.

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 premises. 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.

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 annual basic life support training and 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

Are services safe?

building damage. The plan included emergency contact numbers for staff as well as provision to utilise alternative premises should the building become inaccessible.

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. We were told how any updated best practice guidelines were discussed at clinical team meetings, and practice protocols updated accordingly as a result.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96.3% of the total number of points available (compared with the clinical commissioning group (CCG) average of 98% and national average of 95.4%), with an exception reporting rate of 9% for the clinical domains (compared to the local average of 11% and national average of 9.8%). 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.

It is important to note that the period of data collection for these results related to the time when the practice was registered under the previous partner registration, rather than the current single-handed GP provider. The provider informed us that as yet unverified and unpublished data for the most recent reporting period indicated that further improvements had been made.

Data from 2015/16 showed:

- Performance for diabetes related indicators was variable when compared to the local and national averages. For example:
 - The percentage of patients with diabetes on the register in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months was 70% compared to the clinical commissioning group (CCG) average of 79% and national average of 78%.
 - The percentage of patients with diabetes on the register in whom the last blood pressure reading (measured in the last year) was 140/80 mmHg or less was 87%, compared to the CCG average of 80% and national average of 78%.
 - The percentage of patients with diabetes on the register whose last measured total cholesterol (measured in the preceding 12 months) was five mmol/l or less was 77% compared to the CCG average of 83% and national average of 80%.
 - The percentage of patients with diabetes on the register who had had influenza immunisation in the preceding 1 August to 31 March was 87% compared to the CCG average of 96% and national average of 95%.
 - The percentage of patients on the diabetes register with a record of a foot examination and risk classification within the last 12 months was 95% compared to the CCG average of 94% and national average of 89%.
- Performance for mental health related indicators was slightly lower than the local 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 the record in the preceding 12 months was 91% compared to the CCG average of 94% and national average of 89%.
 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 87% compared to the CCG average of 93% and national average of 90%.

Are services effective?

(for example, treatment is effective)

- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 78% compared to the CCG average of 87% and national average of 84%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 93% compared to the CCG average of 85% and national average of 83%.
- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 80%, compared to the CCG average of 79% and national average of 76%.

There was evidence of quality improvement including clinical audit:

- We looked in detail at two clinical audits completed since the provider took over the running of the practice as an individual. Both of these were completed audits where the improvements made were implemented and monitored. We saw evidence demonstrating that audit was being driven by clinical outcomes of the patients the practice was serving in order to improve the quality of care being delivered to them.
- Findings were used by the practice to improve services. For example, recent action taken as a result included posters being displayed in all consultation rooms to remind clinicians of appropriate medication doses for diabetic patients.

Information about patients' outcomes was used to make improvements. For example, following a significant event analysis, an audit was carried out around the prescribing of omeprazole (a medicine to reduce the amount of acid in the stomach) and naproxen (a nonsteroidal anti-inflammatory drug used to treat pain or inflammation). An updated practice protocol was devised and after two months, in June 2017 a follow up audit indicated improved and safer prescribing of the medicines, rising from appropriate prescribing in 90% of cases to 100% within two months.

The provider was aware of the practice's previous low prevalence of patients with chronic obstructive pulmonary disorder (COPD, a disorder of the lungs). However, the

recent appointment of an advanced nurse practitioner with a background in this area had resulted in an increase of COPD prevalence on the practice's patient list of approximately 30%.

The practice shared evidence with us demonstrating how it had improved prescribing since the current provider had taken over delivery of the services in March 2016 as a single handed provider. The practice had carried out a thorough review of its prescribing trends and updated processes so that for the year 2016/17 the practice had underspent on prescribing by £80,000, having historically overspent in this area.

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 allowed for time to review key policy documents, as well as covering such topics as information governance and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- 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. We saw that targets identified as part of staff personal development plans were in line with the practice strategy for quality improvement and implementation of learning following significant events and complaints. For example, we saw that in recognition

Are services effective?

(for example, treatment is effective)

of the low prevalence of COPD, one of the newly appointed advanced nurse practitioners had a target identified linked to increasing prevalence and that this target was linked in with NICE best practice guidelines.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 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 a six weekly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice was proactive in ensuring 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. The practice showed us a letter received in June 2017 from a local nursing home which praised the GPs for the high quality end of life care offered to two patients who had recently passed away.

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 practice had liaised with teenage patients to discuss issues around consent and the practice's commitment to confidentiality, and had asked them to design a poster highlighting the key issues around consent for this patient population group. This poster was displayed in the waiting area in an effort to raise patient awareness of what they can expect from the practice in maintaining confidentiality.

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.
- Smoking cessation advice was available on site at the practice. Patients could also access a drug and alcohol misuse support worker on site.

The practice's uptake for the cervical screening programme was 73%, which was lower than the CCG average of 80% and the national average of 81%. Again, this figure referred to data collected in 2015/16, prior to the current provider taking over the sole running of the practice. The provider explained that since taking over the practice in March 2016, nursing capacity had been increased with the appointment of a new practice nurse and nurse practitioner and therefore the practice was able to offer an increased number of appointments to facilitate uptake of cervical screening. Clinics were also planned with the patient demographic in mind, to take into account cultural factors such as religious holidays such as Eid. The practice offered more appointments immediately before and following such holidays in recognition that during the holiday period itself patients would not accept appointments. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test.

Are services effective?

(for example, treatment is effective)

Reception staff had responsibility for completing this task on a monthly basis. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice was currently liaising with young female patients with a view to drafting a letter to promote cervical smear uptake further, with the patients' input. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer, and had invited external practitioners to attend at the practice to deliver "call for a kit" clinic sessions for bowel cancer screening.

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. For example, rates for the vaccines given to under two year olds ranged from 85% to 96% and five year olds from 88% to 97%.

The practice had also produced a bespoke congratulations card which it sent to new parents on the birth of a child, and this was used to promote health services available such as the baby clinic.

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.

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.

All of the 19 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 three patients who were also members of the patient participation group (PPG). They told us they were extremely 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. Patients told us of the personalised care they received from clinicians with many specific examples of clinicians going 'above and beyond' to ensure the needs of patients were met.

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

- 95% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 81% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.

- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local and national averages of 86%.
- 88% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 88% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 98% of patients 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%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local and national averages of 91%.
- 66% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

The patients we spoke to during the inspection told us that they found the receptionists and administrative staff to be extremely helpful and caring.

The views of external stakeholders were positive and in line with our findings. For example, the practice had received a letter from a local nursing home praising the high quality care delivered to its residents by the GPs.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals.

Are services caring?

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.
- 86% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

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. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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 signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 339 patients as carers (6% of the practice list). However, the practice was aware that many of these identified patients were coded incorrectly and so was in the process of validating the list. The practice manager informed us that it was felt patients may have inadvertently identified themselves as carers by mistake using the new electronic self check in device in the waiting area. Written information was available to educate patients on what a carer was and to direct carers to the various avenues of support available to them. We saw that the practice was not consistently utilising alerts on the electronic patient records to facilitate staff being aware of who was a carer. The practice manager informed us these would be added as the carer's list was validated.

Staff told us that if families had experienced bereavement, the practice sent them a sympathy card. This card had been designed by the children of practice staff and reminded patients that the practice was available to offer support. Patients were offered a consultation at a flexible time and location to meet the family's needs and/or were given advice on how to find a support service as appropriate.

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 meet the needs of its population:

- The practice demonstrated awareness of the cultural and religious background of many of its patients and planned services accordingly. For example, additional capacity for cervical screening appointments was planned before and following religious holidays such as Eid in recognition of the poor uptake for these appointments during the holiday period itself. This was contributing to a reported increase in uptake for these appointments.
- The practice offered extended hours on a Monday evening until 7.30pm 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.
- The practice provided a range of online facilities, such as repeat prescription ordering.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- Many practice staff were multilingual and interpretation services were used when required.
- Other facilities to improve patient's access to services were also in place, such as a hearing loop for patients with hearing difficulties.
- Consultation and treatment rooms were all situated on one floor, so access for those patients with mobility difficulties was facilitated.
- The practice demonstrated how it was aware of risks associated with the particular patient population it

served, and was engaged in proactively promoting uptake of the MMR vaccine (a combined vaccine to protect against measles, mumps and rubella) in order to protect the fertility of its young patient cohort.

- Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services.

Access to the service

The practice was open between 8am and 6.30pm each weekday apart from Monday, when extended hours appointments were offered until 7.30 in the evening. Surgeries were offered between 8.30am and 12.00 each morning, and between 1.30pm and 4.30pm each afternoon apart from Friday, with Monday evening's extended hours' appointments running between 6.30 and 7.30pm. Patients were also able to access additional extended hours appointments, which were offered from another local practice premises by the local GP federation between 5pm and 9pm on weekday evenings, and between 8:45am and 2:15pm on weekends.

In addition to pre-bookable appointments that could be booked up to one week in advance, urgent appointments were also available for patients that needed them. On the day of inspection, the next available pre-bookable routine appointment was in two days' time.

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

- 53% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 29% of patients said they could get through easily to the practice by phone compared to the CCG average of 73% and national average of 71%.
- 64% 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 84% and the national average of 84%.
- 55% of patients said their last appointment was convenient compared with the CCG average of 81% and the national average of 81%.

Are services responsive to people's needs?

(for example, to feedback?)

- 32% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 44% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 58%.

However, this did not reflect the feedback we received verbally from patients during the inspection; we were told on the day of the inspection by patients that they were able to get appointments when they needed them.

The practice could demonstrate how it was aware of below average patient feedback regarding access to appointments and highlighted to the inspection team numerous measures that had been implemented over a prolonged period of time in an effort to make improvements. For example, a recent change implemented as a result of the most recent published survey included diverting a third telephone line from the administration office to reception during busy times to facilitate patients getting through in order to book appointments. The patients we spoke to were aware of this change and told us of the positive impact it had had on telephone access.

The practice had also increased clinical capacity since March 2016 with the employment of new nursing staff giving an additional ten sessions of advanced nurse practitioner time per week.

The practice had a system to assess:

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

The patient's details were noted and the request passed to the on call GP to allow for an informed decision to be made on prioritisation according to clinical need. In cases where

the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice 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 a complaints leaflet was available for patients from reception.

The practice had logged four complaints that had been received in the previous 12 months; three were received and resolved verbally and one in writing. We looked at the written complaint in detail and found this was satisfactorily handled, dealt with in a timely way, and with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, after a complaint had been received regarding the issuing of a patient's medication, we saw that the practice had contacted the patient to offer an apology and had implemented learning by updating the relevant practice procedure. We were shown meeting minutes from a practice meeting which documented how this learning had been disseminated to staff.

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 displayed a mission statement in the patient waiting area which highlighted the aspiration of providing high quality, safe, patient centred care. The staff we spoke with knew and understood these values. The practice had a clear strategy and supporting action plans which reflected the vision and values and we saw that these were regularly monitored.

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. The practice had also nominated a member of staff as patient liaison officer to facilitate the gathering of feedback from patients and the implementation of learning outcomes from this.
- Practice specific policies were implemented and were available to all staff. Although not all policies we viewed were dated to note when they were created / reviewed, we saw that the practice was in the process of merging documentation onto a new electronic system and were being systematically reviewed as they were uploaded onto this. Those that had already been stored on this new system were dated appropriately.
- A comprehensive understanding of the performance of the practice was maintained, and appropriate action taken to address any shortfalls identified. Practice meetings were held weekly which provided an opportunity for staff to learn about the performance of the practice. Staff we spoke to demonstrated they had an understanding of the practice's performance and of areas the provider had identified to focus on improving. Staff told us how the lead GP was proactive in managing areas identified for improvement.
- A programme of continuous clinical and internal audit was used to monitor quality and to make

improvements. These audits were driven by the needs of the patient population specific to the practice, for example we were shown examples that had been undertaken following significant events and complaints.

- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Staff we spoke with confirmed that learning was disseminated at meetings and were able to discuss specific examples with us, including the changes to practice implemented as a result.

Leadership and culture

On the day of inspection the provider and management team in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the provider and practice manager were approachable and always took the time to listen to all 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 lead GP encouraged a culture of openness and honesty. From the sample of 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 support, truthful information and an appropriate 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 multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. The GP, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.

Are services well-led?

Good 

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

- 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, particularly by the lead GP and practice manager in the practice. All staff were involved in discussions about how to run and develop the practice, and the lead GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The NHS Friends and Family test, complaints and compliments received.
- Staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, the practice nurse told us how feedback had been raised with the practice management and lead GP regarding patients attending for their long term condition review appointments without their current medication. We were told how the practice had responded swiftly and amended the wording of the appointment recall letter to include a reminder for patients to bring their medication with them to the appointment. Staff told us they felt involved and engaged to improve how the practice was run.

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 through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, members of the PPG informed us how the practice had responded to patient feedback regarding accessing appointments. The practice had displayed additional literature in the waiting area to promote alternate methods of booking appointments, for example online rather than over the telephone, and had introduced an additional telephone line during busy periods to help cope with the high demand. PPG members told us how they felt the practice was extremely responsive to patient feedback and the practice engaged well with the PPG. The PPG and practice were jointly planning to run a health education event for patients in the coming months to raise awareness of common health issues, possible avenues of support available and to promote self-care.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The lead GP informed us that the CCG had been in discussion with the practice in light of the high quality palliative care offered with a view to rolling out the practice's protocol across the wider area.

The GP also discussed how access issues may be further addressed. The practice was exploring how it could incorporate remote consultations, via programmes such as 'Skype' to better meet the needs of patients.

The practice had planned to run a pre-diabetes roadshow for patients in September 2017 in order to raise patient awareness and signpost patients to relevant support and to make healthy lifestyle choices. The lead GP valued his role as a GP trainer, and in the past had supported trainee GPs at the practice in the production of a piece of work around diabetic retinal screening which won a national award.