

Dr Imran Gohar

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Dr Imran Gohar GP practice on 17 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice had systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Medicines were well managed and medicines related stationery was secure.
- The practice had a sustained track record of safety supported by accurate performance information.
- Patient's physical, mental health and social needs were holistically assessed, and their care, treatment and support were delivered in line with legislation, standards and evidence-based guidance.
- Information about the outcomes of patient's care and treatment were routinely collected and monitored.
- People who used the services were empowered and supported to manage their own health, care and wellbeing.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

Summary of findings

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

Summary of findings

The six population groups and what we found

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

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

Dr Imran Gohar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector with a GP specialist adviser.

Background to Dr Imran Gohar

The registered provider is Dr Imran Gohar. The practice is located at Sydenham House Doctors Surgery, Harlow, Essex. Their web address is sydenhamhousesurgery.co.uk. The practice provides NHS primary medical services through a General Medical Services (GMS) contract to approximately 2,085 patients. It is part of the NHS West Essex Clinical Commissioning Group (CCG) which is made up of 39 general practices.

The practice provides services to approximately 2085 patients within the Netteswell ward area that is near the town of Harlow. The practice's population is in the fourth decile for deprivation as measured by the Index of Multiple Deprivation. This is the official measure of relative deprivation for small areas in England. The lower the decile

the more deprived an area is compared to the national average. The practice population ethnic profile is predominantly White British. The practice has a higher elderly population than the national averages with 35% of the practice list aged over 65 years compared to the national average of 27%. The average male life expectancy for the practice area is 77 years which is lower than the national average of 79 years; female life expectancy is 82 years which is lower than the national average of 83 years.

The provider, Dr Imran Gohar, is a sole practitioner, and employs two part-time female GPs that provide three sessions a week. There are also two part-time practice nurses, who provide five clinical sessions a week. The administrative team is made up of the practice manager and three receptionists.

The practice is closed at weekends and has opted out of providing an out-of-hours service. West Essex commissioning group have introduced an evening and weekend GP service. Patients can pre-book an appointment and be seen at one of six locations throughout the West Essex area. Appointments are booked through the practice. The Partnership of East London Cooperatives (PELC) provide the GP out-of-hours service for patients registered to surgeries in West Essex.

Are services safe?

Our findings

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

Safety systems and processes

Patients were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong.

- There were comprehensive systems to keep people safe, which took into account current best practice. The whole team was engaged in reviewing and improving safety and safeguarding systems. Patients who used the services were at the centre of safeguarding and protection from discrimination. The practice worked with other agencies to support patients and protect them from neglect and abuse.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

- Staff were able to discuss risk effectively with people using the service.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

A proactive approach to anticipating and managing risks to patients who use services was embedded and was recognised as the responsibility of all staff.

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

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- There were effective 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.

Are services safe?

- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a sustained track record of safety supported by accurate performance information.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. There was ongoing, consistent progress towards safety goals reflected in a zero-harm culture.

Lessons learned and improvements made

There was a genuinely open culture in which all safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- All staff were open and transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a clear picture of quality.
- Learning was based on a thorough analysis and investigation of things that went wrong. All staff were encouraged to participate in learning to improve safety as much as possible.
- Lessons were learned and communicated widely to support improvement in other areas where relevant, as well as services that were directly affected. Opportunities to learn from external safety events and patient safety alerts were also identified. Improvements to safety were made and the resulting changes were monitored.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. Care and treatment was based on risk assessments that balanced the needs and safety of patients registered at the practice with their rights and preferences.
- We saw no evidence of discrimination when making care and treatment decisions.
- Patients could book nurse and GP telephonic consultations, book their appointment and request repeat prescriptions on line. The practice was soon to commence a pilot video consultation.
- The practice promoted the use of NHS approved healthcare applications for mobile phones, for example Talking Point, a community facing dementia advice portal and Rally Round an online platform to organise carers for children and adults.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Staff demonstrated that they had a thorough understanding of the physical and psychological needs assessment in patients with long-term conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD). They had well established programmes of care, incorporated motivational educational sessions to educate and empower patients to manage their condition optimally.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.

- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.

The practice was not an outlier for any QOF condition indicators.

- The practice performance around the 11 measured tasks for diabetes was similar at 93% compared to the CCG of 90% and national of 92%. Exception recording in this indicator was 6.3% compared with the CCG of 6% and national of 5.5%.
- The practice performance around the three measured tasks for asthma was similar at 88% compared to the CCG 90% and national of 89%. Exception recording in this indicator was 4.7% compared with the CCG of 3% and national of 4.3%.
- The practice performance around the six measured tasks for chronic obstructive pulmonary disease was lower at 80% compared to the CCG and national of 89%. Exception recording in this indicator was 6.3% compared with the CCG of 6% and national of 5.5%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice has a same day appointment policy for children under five, longer and combined appointments for parent and child were also available.

Are services effective?

(for example, treatment is effective)

- The practice had a policy to follow up on children that did not attend their booked appointment or had a large number of A&E attendances.
- All staff had a good level of knowledge of relevant guidance for taking informed consent from children and young people using the Gillick competencies framework.

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

- The practice's uptake for cervical screening was 80%, which was in line with the 80% coverage target for the national screening programme.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Recently retired patients were identified and given advice on local resources and on how to live healthily.

People whose circumstances make them vulnerable:

- 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 held a register of patients living in vulnerable circumstances including and those with a learning disability.
- The practice had a protocol in place where patients identified on the moderate and severe frailty index register had an alert on their record to highlight to the clinicians to enquire about any falls during the last 12 months and to consider a medication review.

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

- There was a process in place to identify patients who may not be able to manage their medicine. The GP would put the patient on weekly prescriptions and collection would be monitored and followed up if required.
- Patients with poor mental health, including dementia, were referred appropriately to enable them to access a variety of treatments (including listening and advice, IAPT and counselling).

- There were established links with services, to enable practice staff to seek advice from, or refer patients to: this included mental health services, learning disability services and autism services.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 100%; CCG 89%; national 91%); and the percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years (practice 100%; CCG 91%; national 88%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Findings were used by the practice to improve services. For example following an audit of patients that received a particular type of medicine that required blood tests, the audit identified not all patients had this investigation performed; the practice had amended its systems so all patients received the required blood tests when required. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 93% and national average of 96%. The overall exception reporting rate was 11% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Are services effective?

(for example, treatment is effective)

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice undertook a consultation following discharge from hospital either by a home visit, a face to face appointment or by telephone. Patients records were updated to reflect any additional needs; particularly for older people and people with long term conditions.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent in supporting patients to live healthier lives, including identifying those who needed extra support. They used a targeted and proactive approach to health promotion and prevention of ill-health, and they used every contact with patients to do so.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

Practices around consent and records were actively monitored and reviewed to improve how patients were involved in making decisions about their care and treatment.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

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

Kindness, respect and compassion

Feedback from patients who used the service, those who were close to them and stakeholders was continually positive about the way staff treated patients. Patients told us that staff went the extra mile and their care and support exceeded their expectations.

- Staff understood and respected the personal, cultural, social and religious needs of patients and related them to their care needs; they took these into account in the way they delivered services. This information was recorded and shared with other services and providers.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients dignity. Relationships between patients who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- The practice gave patients timely support and information.
- 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.
- Staff recognised that patients needed to have access to, and links with, their advocacy and support networks in the community and they supported patients to do this.
- All of the 27 patient Care Quality Commission comment cards we received were positive about the service experienced. This was line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 308 surveys were sent out and 116 were returned; completion rate of 38%. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 92% of patients who responded said the GP gave them enough time; CCG - 85%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 92%; national average - 92%.
- 89% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 84%; national average - 86%.
- 88% of patients who responded said the nurse was good at listening to them; CCG and national average of 91%.
- 86% of patients who responded said the nurse gave them enough time; CCG and national average of 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 90% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG and national average of 97%.
- 88% of patients who responded said they found the receptionists at the practice helpful; CCG - 84%; national average - 87%.

GP survey results were either better than, or in line with CCG and national averages. The practice was aware of the results and told us that the practice was aware of data and continually looked of ways of improving. The practice had undertaken in-house surveys and the nurses responses were now in line with or slightly above CCG and national percentages.

Involvement in decisions about care and treatment

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

Are services caring?

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Patients were also told about multi-lingual staff that might be able to support them. Different ethnic populations were registered at the practice; the level of English understood by the patient was well documented. The GP was able to understand three of the main spoken languages and they also used a language translation service.
- Staff communicated with patients in a way that they could understand
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. Staff would identify carers during an appointment when they discussed their welfare. 'Are you a carer?' was a question on the new patient registration form. There was a poster in the waiting area asking if patients were carers to let a staff member know so their records could be updated. Support group information was available in the waiting areas. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 25 patients as carers (1.2% of the practice list). The practice had access to a carer's champion that would give support and local advice.

- Following bereavement, the GP would call or visit relatives or carers to offer condolences and assess if any additional support might be required. Information was available to signpost relatives or carers to appropriate services such as counselling where indicated.

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:

- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group CCG average of 84% and the national average of 86%.
- 91% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 79%; national average - 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 86% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 86%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

Services were tailored to meet the needs of the patient and were delivered in a way to ensure flexibility, choice and continuity of care. Patient's individual needs and preferences were central to the delivery of tailored services.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice made reasonable adjustments when patients found it hard to access services. There were GP and nurse appointments available until 7.30pm on a Tuesday. GP and nurse appointments were available through a 'hub' commissioned by West Essex CCG. Patients could book through the surgery appointments for Wednesday and Friday evening between 6pm and 10pm and between 8am to 8pm Saturday and Sunday. These appointments were held at Keats House Health Centre in Harlow.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.
- The facilities and premises were appropriate for the services delivered.
- Patients were able to receive travel vaccinations available on the NHS. Those only available privately were referred to other clinics for vaccines available privately.
- The practice made reasonable adjustments when patients found it hard to access services. For example, there were accessible facilities, which included automatic doors to enter the building, a disabled toilet and baby changing facility.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

- The practice was involved in an integrated care programme project; they focused on the top five percent of high risk patients that made up 80% of their admissions through A&E. They provided special training for both professional and family carers on how to reduce frequent hospital visits. Consultants were part of the team that identified new ways to provide care without involving the hospital itself. A lead nurse for frailty and dementia was appointed by the project. They worked closely with the A&E staff and focussed on ambulance arrivals to identify frail older patients; they aimed to ensure a timely clerking in and if suitable same day discharge. Changes in access to pharmacy and supplies had also proved to save time and money.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice offered weekend hub appointments; this meant that when elderly patients needed to have a family member to attend with them they could.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs in order to deliver care more effectively. Monthly meetings with wider members of the healthcare team were held to review more complex and vulnerable patients.

People with long-term conditions:

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

Are services responsive to people's needs?

(for example, to feedback?)

worked closely with the local community health providers including the community matron and respiratory team to deliver a multidisciplinary package of care.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice had a policy in place to offer children under five a same day appointment.
- The practice held a list of looked after children and ensured they were up to date with immunisations and they all had care plans that were regularly reviewed.
- Appointments were available before and after school hours.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, patients could book an evening or weekend GP, nurse or healthcare appointment and, this service was located in six locations throughout the CCG including Harlow. Appointments were booked through the practice.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice carried out learning disability annual health reviews and 100% of these patients had received a follow-up when we checked the 2016-2017 data available to us.
- Vulnerable patients were given priority appointments which would be extended to a twenty minute appointment or longer if clinically indicated, this would be noted on the patients file.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The GP at the practice had undertaken further training in substance misuse, and provided a service for patients with this need in the practice.
- The practice was sensitive to people with poor mental health. They offered them greater flexibility regarding access to and duration of appointments, including offering them appointments at the end of morning surgery or during quieter times. The practice felt this was well received by patients, providing individualised care in a quiet and supportive environment. This was intended to reduce potential stress for the patient and reassure them they would be treated without fear or prejudice.
- The practice told us they had above average number of older patients which resulted in them having an above average number of dementia patients.

Timely access to the service

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

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

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 308 surveys were sent out and 116 were returned; completion rate of 38%.

- 87% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.

Are services responsive to people's needs? (for example, to feedback?)

- 96% of patients who responded said they could get through easily to the practice by phone; CCG – 62%; national average - 71%.
- 84% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 86%; national average - 85%.
- 88% of patients who responded said their last appointment was convenient; CCG and national average - 84%.
- 92% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%.
- 77% of patients who responded said they don't normally have to wait too long to be seen; CCG - 54%; national average - 58%.

We spoke to the practice about the high patient satisfaction response and asked how they achieved such good figures. The GP told us they did not use any automated answering

system as all calls were answered by a receptionist. The practice mission statement was to provide patients with high quality, accessible care in a responsive, courteous manner. This ethos was evident in all staff interactions both with patients and the inspection team.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.

The complaint policy and procedures were in line with recognised guidance. No complaints were received in the last year. We reviewed the policy and process and found that complaints received would be dealt with in a timely way.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The practice was in their second 100 day challenge to reduce unplanned admissions from their top 2% frailty patients.
- Being open (patient safety alert 2009) principles were used by all leaders this ensured a culture of openness, honesty and transparency, which included an apology and explanation of what happened if required.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- Their statement of vision and values were driven by quality and sustainability. It had been translated into a strategy and well-defined objectives that were achievable and relevant.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

- The practice monitored progress and discussed this in meetings with all staff

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. Staff were supported to learn and develop and feedback that their appraisal supported their development.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Governance arrangements were proactively reviewed and reflect best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Good 

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Leaders had an inspirational shared purpose, they strove to deliver and motivate staff to succeed in delivering bespoke care.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

The practice had processes to manage current and future performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve identified concerns.
- The organisation reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.

- There was a holistic understanding of performance, which sufficiently covered and integrated the views of people with quality, operational and financial information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor and report performance of the delivery of quality care was accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Staff received helpful data on a daily basis, which supported them to adjust and improve performance as necessary.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example adjustments had been made to the appointments system because of representations from patients to improve the system for the patient population.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

Are services well-led?

Good 

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

- There was a focus on continuous learning and improvement at all levels within the practice. The practice had received funding to continue the 100 day challenge to focus on avoidable hospital admissions.
- The practice employed two part time female GPs following feedback from some patients.
- Staff knew about improvement methods and had the skills to use them.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.