C.B.Patel & Partners

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

We carried out a comprehensive inspection of CB Patel and Partners on 29th April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the care provided to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Arrangements were in place to ensure patients were kept safe. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice guidance.
- We saw from our observations and heard from patients that they were treated with dignity and respect and all practice staff were compassionate.
- The practice understood the needs of their patients and was responsive to them. There was evidence of continuity of care and people were able to get urgent appointments on the same day.
- There was a culture of learning and staff felt supported and could give feedback and discuss any concerns or issues with colleagues and management

However, there were also areas of practice where the provider should make improvements:

- The practice should ensure that all staff that act as chaperones receive chaperone training.
- The practice should ensure that references for all staff are sought before staff start work at the practice.
- The practice manager should ensure they have the appropriate training to carry out their duties as fire marshal.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and staff told us there were enough staff to keep people safe. A slot for significant events was on the monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually. All staff had received child protection and adult safeguarding training. However, appropriate pre-employment checks had not been completed for all staff before they started work at the practice. An infection control audit had been carried out during the last year and improvements that had been identified were included in an action plan and completed on time. However, some administration staff who were required to act as chaperones on occasions had not received chaperone training.

Are services effective?

Good

The practice is rated as good for effective.

Data showed patient outcomes were average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's capacity to make decisions and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out staff appraisals and had established personal development plans for most staff. There was evidence of multidisciplinary working to discuss the needs of complex patients especially those on care plans. These meetings were attended by community matrons, district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Are services caring?

Good

The practice is rated as good for caring.

Summary of findings

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Patients who had care plans received annual reviews or more frequently where needed.

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients 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 they wished to receive. Patient feedback on the CQC patient comment cards we received was positive. GP's told us they would make phone calls to families who had suffered bereavement and offer to refer them to appropriate services for support.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice reviewed the needs of their local population and engaged with Clinical Commissioning Group (CCG) to secure service improvements where these were identified. All vulnerable patients had a named GP. There was evidence of continuity of care and people were able to get urgent appointments on the same day. However, some patients reported having difficulty getting through to the practice by phone. The practice was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice reviewed complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon in a timely manner. The practice used a telephone translation service but the GPs spoke most of the languages used by their patient population. The premises were accessible to patients with disabilities as the surgeries were on the ground floor. Toilets were accessible to wheelchair users.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

High standards were promoted and owned by all practice staff and teams worked together across all roles. There were clear governance arrangements in place and a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us they

Summary of findings

could give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients and that there was a culture of learning.

The practice gathered feedback from patients through an internal patient survey organised by their patient participation group (PPG), who met bi-annually and we saw changes made as a result of feedback from this group.

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

Patients over 75 years had a named GP to co-ordinate their care. The practice had 985 patients aged 65 years and over, of which more than 70% had received flu immunization in the 2014/2015. There was a register for older people who had complex needs and required additional support and care plans were in place to ensure these patients and their families received coordinated care and support. They were involved in an 'Integrated Care Pilot' scheme to improve the outcomes for older patients and patients with complex care needs. These patients were referred directly to Geriatric Consultants whenever necessary. We saw carers of older people were noted on the electronic patient record system and the practice communicated with them whenever necessary. The practice works closely with external voluntary services to help reduce the risk of unplanned admissions to hospital, and enable patients to remain at home, where possible.

People with long term conditions

Good

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. Patients in these groups had a named GP, care plans and a structured annual review to check that their health and medication needs were being met They were allocated longer appointment times of between 30 and 45 minutes and home visits were available when needed.

The practice had adopted an integrated care model and as such worked closely with a care coordinator employed by the CCG who supported diabetic patients across four practices.

Families, children and young people

Good

The practice offered appointments on the day for all children under five when their parent requested the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they actively promoted sexual health advice and provided screening for chlamydia to young people. They had systems to manage and review risks to children and young people who were vulnerable or at risk of abuse and provided maternity care and family planning services. We saw evidence to

Summary of findings

confirm they worked in partnership with midwives, health visitors and school nurses to meet patients' needs. They offer a full range of immunizations for children in line with current national guidance and achieved a vaccination rate of 98% and above for 17 out of the 18 childhood immunizations in the past year.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. They had extended opening one day a week and online services for ordering repeat prescriptions, booking appointments and getting test results were available. They also offered phone consultations for patients who could not attend the surgery. The practice offered a full range of health promotion and invited patients over 40 years of age to have an NHS health check.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. All vulnerable patients had a care plan that was reviewed annually. The practice carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities. Practice staff had access to an interpreter and translation service via language line to ensure that those patients whose first language was not English could access the service. The practice was accessible to disabled patients.

People experiencing poor mental health (including people with dementia)

Good

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. They held a register of patients experiencing poor mental health who they invited to attend an annual physical health check. They worked closely with other services such as the Community Mental Health Teams to ensure patients' needs are regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access counselling, emergency care and treatment when experiencing a mental health crisis.

Summary of findings

The practice was pro-active in screening patients for dementia to facilitate early referral and diagnosis where dementia was indicated. QOF data showed the practice had scored 100% for conditions commonly found amongst older people such as dementia.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection and received 42 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

Most of the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. They said the care was good and staff were helpful and treated them with dignity and respect. However, three patients said they felt not listened to on occasions by some of the doctors and often felt rushed.

Most of the patients we spoke with had been registered with the practice for many years and told us most GPs gave consistently good care. The national GP patient survey found that 81% of respondents described their overall experience of the practice as good, however only 61% said that they would recommend the practice to someone new.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- The practice should ensure that all staff that act as chaperones receive chaperone training
- The practice should ensure that references for all staff are sought before staff start work at the practice
- The practice manager should ensure they have the appropriate training for them to carry out their duties as fire marshal.

C.B.Patel & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an expert by experience who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to C.B.Patel & Partners

CB Patel and Partners provides GP primary care services to approximately 9000 people living in South Middlesex. The practice is staffed by five GPs, three female and two males who work a combination of full and part time hours. The practice employs two nurses, a phlebotomist, a practice manager and four administrative staff. The practice holds a General Medical Services (GMS) contract and was commissioned by NHS England London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice was open from 8am to 7pm Monday to Thursday and 8am to 6.30pm on Fridays. The telephones were manned daily whilst the practice was open and a recorded message was available at all other times. Appointment slots were available throughout the opening hours. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

The practice has opted out of providing out-of-hours services to their own patients. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website. The practice provides a wide range of services including clinics for asthma, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provides health promotion services including a flu vaccination programme, travel vaccinations and cervical screening.

The practice is located in an area that is home to a diverse range of people and communities, with significantly greater concentrations of people from minority ethnic backgrounds resident in Hayes. Major ethnic minority groups include Indian (13%), White Other (6%) and Black-African (4%) In addition, the presence of the airport means that the borough looks after a high number of children seeking asylum in the UK.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 29th April 2015. During our visit we spoke with a range of staff (doctors, practice manager and administrative staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed policies and procedures, patient treatment records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. All staff were encouraged to log any significant event or incident and we saw there was a template for this that was accessible on all computer desk tops. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw that there had been a recent incident where a patient was given a wrong prescription due to having the same surname and the error was noticed by the pharmacy. The practice immediately implemented a new prescription process of asking for the patients both names and date of birth, before giving out repeat prescription and had noted the high risk associated with taking the wrong medication.

We reviewed safety records, incident reports and minutes of meetings from August 2014 where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. Significant events was a standing item on the practice meeting agenda and completed a significant event analysis (SEA) annually which included identifying any learning from the incident. There was evidence that the practice had learned from these and that the findings were shared with all staff. For example, we saw that where blood samples had been sent to a hospital without a label, the new checking process was discussed with all staff including administrators.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with told us of a recent alert they had discussed that had been circulated by the CCG regarding missing children who were the subject of safeguarding arrangement. They also told us that alerts were discussed at monthly practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers.

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding children. Clinicians were trained to level three and non-clinical staff were trained to level one. All staff had received safeguarding training in adult protection. All non-clinical staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located in safeguarding intranet pages and displayed on the walls of the treatment rooms and the practice manager's office.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice electronic patient records. This included information so that staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and vulnerable adults. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services. The safeguarding lead attended child protection case conferences and reviews where appropriate and reports were sent if staff were unable to attend.

Good

Are services safe?

Hospital A&E reports were sent to the head receptionist which enabled the practice to monitor and identifying patients with a high number of A&E attendances and take appropriate action.

A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone administration staff had been asked to carry out this role. However, we were told that chaperone training had not been undertaken by some of these staff members, although staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff with chaperone duties had Disclosure and Barring Service (DBS) checks. (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).

Medicines management

Medicines were stored in medicine refrigerators in one of the nurse's treatment room. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The practice nurse was responsible for generating repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times in locked drawers in the nurses room. The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

We were told the nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance, although we did not see any on the day of our inspection. However, we have subsequently seen evidence of these. The Health Care Assistants administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the nurse prescriber; we saw evidence to confirm this. We saw evidence that the nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed, which was all diabetic medication.

GPs reviewed their prescribing practices as and when medication alerts were received. We saw that GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to keep abreast of updated medication information.

The practice was not a dispensing practice and did not hold controlled medication.

Cleanliness and infection control

We observed the premises were clean and tidy. Cleaning of the premises was carried out daily by a cleaning agency that was contracted by the practice. Cleaning records were kept which showed a list of what had been cleaned at each visit. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training on infection control as part of their induction and updated every two years. An infection control audit had been carried out in August 2014 by NHSE which had identified the need to have a written cleaning schedule and Control of Substances Hazardous to Health Regulations 2002.(COSHHE) protocols which we saw had been actioned. An infection control policy and supporting

procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they would always wear gloves to accept specimens from patients as stated in the infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed that the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. However, on the day of our inspection we noted that portable electrical equipment testing (PAT) had not been carried out for two years. Since our inspection we have received information to confirm that all equipment was PAT tested in May 2015. A schedule of testing is now in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in January 2015.

Staffing and recruitment

The practice had a recruitment policy in place and up to date. However, we found in some cases appropriate pre-employment checks had not been completed for all staff before they started work at the practice. We looked at a sample of recruitment files for GPs, administrative staff and nurses and found most contained proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. However, we checked eight staff files and found that references for three staff had been obtained after they started working at the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. There were procedures to follow in the event of staff absence to ensure smooth running of the service. The office manager occasionally provided cover in reception during busy periods.

The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

The practice manager told us they had recently reviewed the staffing levels and skill mix. They had identified a need to increase their GP staff cover and had recruited an additional salaried GP who was due to start at the beginning of May 2015.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on the intranet for all staff. The practice manager was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk log maintained by the practice manager with clear actions required and date to be completed clearly noted. We saw that any risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health. For example, the practice kept a register of vulnerable patients which provided alerts to staff to follow up on attendance and results when patients in this group where referred for tests and medical procedures. This ensured they were able to inform GP's when these patients had not attended for tests.

Good

Are services safe?

A fire risk assessment had been undertaken that included actions required to maintain fire safety. For example, we saw it had identified fire alarm tests should be carried out every week and fire drills to occur quarterly. We saw evidence to confirm these actions were carried out. We were told the practice manager was the fire marshal, however they had not attended relevant training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff were up to date in basic life support training. The practice had easily accessible resuscitation equipment which included a defibrillator and oxygen. Emergency medicines were stored with the resuscitation equipment and included medicines for management of cardiac arrest, anaphylaxis, chest pain, seizures and asthma attacks. All emergency medicines were in date and expiry dates were checked weekly by the practice nurse.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This covered areas such as long or short term loss of the main premises, loss of the computer system/ essential data, loss of the telephone system, incapacity of GPs, flu pandemic and weather conditions. The document also contained relevant contact details for staff to refer to. For example, contact details of utility suppliers, all staff contact numbers and email addresses and contact details for locum doctors. The plan was reviewed on an annual basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice developed clinical pathway templates in relation to certain conditions such as back pain which was linked to NICE guidance. We saw the practice had weekly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The GPs and nurses told us staff completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need. Discharge summaries were sent to the practice manager who would liaise with the relevant GP to book an appointment, either at the surgery or the patients' home.

The GPs told us there was a lead for specialist clinical areas such as musculoskeletal, minor surgery and women's care. One practice nurse also had additional training in diabetes and was able to prescribe diabetic medication. GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. Our review of the clinical meeting minutes confirmed that this occurred. For example, we saw they had recently discussed new guidelines relating to Rheumatoid Arthritis (RA). Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Patients told us they had never experienced any discrimination at the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been undertaken in the last year. All were completed audits that is, the practice had re-audited. The practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of patients with COPD to ensure that prescribing was in line with nice guidance and the Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2014 guidance. On the first audit the number of patients whose prescriptions were in line with the guidance was 58 out of 80. After intervention, on re-audit the number of patients whose prescriptions met the criteria had increased to 80. This was a full cycle audit which showed positive outcomes for patients.

GPs told us they were committed to maintaining and improving outcomes for patients. However we noted the QOF report from 2012-2013 showed the practice scored 984 out of 1000 and QOF information for 2013-2014 indicated the practice had not maintained this level of achievement scoring 637 out of 900, although this score was still 3.2 points above the CCG average. We discussed this with the practice and were told this was due to some GP locums not picking up QOF issues and/or completing appropriate paperwork. The practice manager was now taking the lead for QOF and showed us evidence that the points for this year had increased.

Doctors in the surgery undertake minor surgical procedures in line with their registration and NICE guidance. The staff are appropriately trained and keep up to date. They also regularly carry out clinical audits on their results and use that in their learning.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP's. They also checked that all routine health checks were completed for long-term conditions such as asthma and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had a good understanding of best

Good

Are services effective?

(for example, treatment is effective)

treatment for each patient's needs. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Representatives from the CCG routinely attend the monthly meeting and feedback on areas where there is an increase in the trend for referrals and/or areas of increased spends for prescribing. This benchmarking data showed the practice had outcomes that were similar to other services in the area for prescribing.

Effective staffing

The practice staff team included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.)

The staff induction programme covered a range of topics such as basic lifesaving, child protection and infection control. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to both develop them and ensure they had the knowledge and skills required to carry out their roles. For example, reception staff had received information governance training, and the practice manager had completed a project management course.

Non–clinical staff told us they had regular opportunities to hold discussions about their work during the week, as the practice manager operated an 'open door' policy. All staff received annual appraisals which identified learning needs. Non-clinical staff were appraised by the practice manager and clinical staff were appraised by one of the partners. Staff records demonstrated that appraisals were up to date.

We saw performance and personal development were discussed at these meetings. There were arrangements in place to support clinical staff through the revalidation process. For example the salaried GPs were supported to attend study days in regards to any updates in key aspects of their role such as dementia training.

Staff we spoke with confirmed that the practice was proactive in providing training and funding for development courses. For example, a receptionist had been trained as a phlebotomist.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from out of hour's providers the NHS111 service and local hospital including discharge summaries were received electronically. All relevant staff were aware of their responsibility for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The practice manager circulated the documents and results to the relevant GPs who were responsible to carry out the action required. All staff we spoke with understood their roles and felt the system in place worked well. We were advised that there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients. These meetings were attended by community matrons, district nurses, social workers, palliative care nurses, and decisions about care planning were documented in a shared care record. Staff felt this system worked well. The GPs told us that they would often have ad hoc discussions outside of these meetings when they had serious concerns about patients.

The practice had adopted an integrated care model and as such worked closely with a care coordinator employed by the CCG who supported diabetic patients across four practices.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Good

Are services effective?

(for example, treatment is effective)

a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. An electronic system was also in place for making referrals for tests or to see specialists and staff arranged hospital appointments manually via the phone, fax or emails. A record of each referral including the sent date was maintained on a spreadsheet by the administration staff to monitor for any delays. Urgent two week referrals for suspected cancer symptoms were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in relation to assessing a person's capacity to give consent. All clinical staff had received training on the Mental Capacity Act 2005. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they might use it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of these patients to help ensure they received the required health checks. These patients were offered annual review appointments with their carers during which they were supported in making decisions about their care plans.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this.

Health promotion and prevention

All new patients who registered with the practice had their height, weight and blood pressure checked. The GP was informed of all health concerns detected and these were followed-up in a timely manner. GPs told us they would use their contact with patient's to help maintain or improve mental, physical health and wellbeing. For example they would take a patients' blood pressure and on occasions had offered opportunistic diet and nutrition advice.

The practice also offered NHS Health Checks to all patients aged 40-75 without a known chronic condition. Screening for breast, bowel and cervical cancer was offered in line with national standards.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We saw they had achieved a vaccination rate of 98% and above for 17 out of the 18 childhood immunizations in the past year.

A wide range of information was displayed in the waiting area of the surgery and on the practice website to raise awareness of health issues including information on cancer, meningitis in children, flu and measles.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and a survey of patients undertaken by the practice's Patient Participation Group. (A selection of patients and practice staff who meet at regular intervals to decide ways of making a positive contribution to the services and facilities offered by the practice to the patients.) The evidence from both these sources showed patients were satisfied with their experience at the practice. For example 83% of patients in their survey said the practice was good, very good or excellent and of the 130 patients who responded to the GP survey 81% describe their overall experience as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 81% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time as compared to 85% and 81% respectively for the CCG.

We spoke with 13 patients and all said they were treated with respect, dignity and compassion by all the practice staff. Patients said the care was good and staff were friendly, professional and accommodating. Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 42 completed cards and all were positive about the service experienced. Patients felt the practice offered a good service and staff were helpful, caring and took the time to explain everything. They said that all staff treated them with dignity and respect.

We observed staff to be caring and compassionate towards patients attending the practice and when speaking to them on the telephone. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

Staff told us that they had never witnessed any instances of discriminatory behaviour or where patients' privacy and dignity had not been respected. They said there were some patients whose circumstances made them vulnerable such homeless people or people experiencing poor mental health, who often came to the surgery, but the practice was clear about its zero tolerance for discrimination and made it clear to all patients. The lead GP told us they would investigate all such incidents and any learning identified would be shared with staff and patients.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in this area. For example, data from the national GP patient survey from July 2014 showed 76% of practice respondents said the GP involved them in care decisions and 79% felt the GP was good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received with most GPs. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. However, it was very rarely used as the GP's spoke the same languages as the majority of their patients.

The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were positive about the emotional support provided by staff at the practice and this was reflected in the patient survey information we reviewed and the comment cards we received. For example, patients described how staff responded compassionately when they had been diagnosed with certain conditions.

Notices in the patient waiting room and information on the patient website signposted people to a number of support

Good

Are services caring?

groups and organisations. The practice computer system alerted GPs if a patient was also a carer. Carers were asked to complete carer's forms where appropriate and there was written information available for carers to ensure they understood the various avenues of support available to them.

There was a robust system of support for bereaved patients both provided by the GP's and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. People were given the option to be referred for bereavement counselling or signposted to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice worked closely with the palliative care nursing team and held quarterly meetings with them. Deaths of patients were discussed at the monthly practice team meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. They were aware that a large number of immigrants had recently been housed in the area, with a correspondingly high demand on medical and social agencies. For example, they took up additional consultation time and placed high demands on their baby immunisation clinics and external health visiting services.

The practice also provided general medical services to a large residential mental health unit and we saw evidence that 75 out of 78 of these patients had received a physical health check up in the past year. A register of patients experiencing poor mental health was kept and these patients were also invited to attend annual physical health checks. They regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia, such as CMHT teams, to ensure those patients' needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access counselling, emergency care and treatment when experiencing a mental health crisis.

The practice was pro-active in screening patients for dementia to facilitate early referral and diagnosis where dementia was indicated. QOF data showed the practice had scored 100% for conditions commonly found amongst older people such as dementia.

The Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example avoidable A&E attendances and integrated care pathways.

Patients over 75 years had a named GP to co-ordinate their care and are offered an annual health check and vaccinations such as Influenza, Pneumococcal and Shingles. The practice had 985 patients aged 65 years and over, of which more than 70% had received flu immunization in the 2014/2015. There was a register for older people who have complex needs and required additional support and care plans were in place to ensure these patients and their families receive coordinated care and support. They were involved in an 'Integrated Care Pilot' scheme to improve the outcomes for older patients and patients with complex care needs. These patients were referred directly to Geriatric Consultants whenever necessary. We saw carers of older people were noted on the system and the practice communicated with them whenever necessary. The practice works closely with external voluntary services to help reduce the risk of unplanned admissions to hospital, and enable patients to remain at home, where possible.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed of between 30 and 45 minutes.

The practice offered appointments on the day for all children under five when their parent requested the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they actively promote sexual health advice and provides screening for chlamydia to young people. They had systems to manage and review risks to children and young people who are vulnerable or at risk of abuse and provide maternity care and family planning services. We saw evidence to confirm they work in partnership with midwives, health visitors and school nurses to meet patients' needs.

The practice offered working aged patients access to extended appointments on a Monday to Thursday. They also offered on-line appointments, online ordering of repeat prescriptions, and telephone consultations to speak with the GP or nurse and to get test results.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, they increased the amount of the appointments available on a daily basis.

Tackling inequity and promoting equality

We were told by staff that a high proportion of the practice population did not speak English as their first language, however the GP's spoke most of the languages spoken by the patients. The staff also had access to language line.

The premises were accessible to patients with disabilities and the toilets were accessible to wheelchair users. The corridors were wide enough to accommodate mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice did not provide equality and diversity training for its staff, however staff we spoke with confirmed that they had had discussions in practice meetings about equality and diversity issues and that it was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 8am to 7pm Monday to Thursday and 8am to 6.30pm on Fridays. The telephones were manned daily whilst the practice was open and a recorded message was available at all other times. Appointment slots were available throughout the opening hours. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments on the practice website which allowed patients to book appointments and home visits, order repeat prescriptions and access test results. Information was displayed in the practice waiting room and on the website directing patients to the NHS 111 out of hour's service when the practice was closed. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hour's service was also provided to patients in the practice information leaflet.

Patients were generally satisfied with the appointments system. However, some patients we spoke with in the practice said it was sometimes difficult to get through on the phone and often when you did there were no appointments available. Comments received from patients and on the CQC comment cards showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. All patients we spoke with told us they had always been able to get an emergency appointment and if they had not been able to see the doctor the same day, they said they were able to talk with them on the phone.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and in the practice information leaflet was available and given to patients when they registered. There was also information about how to contact other organisations such as NHS England to make a complaint displayed on the walls. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last twelve months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging.

The practice kept a complaints log and we were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all 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 manager told us their vision was to provide a high standard of family health care in a warm friendly caring environment with particular emphasis being placed on disease prevention and management. They said they aimed to deliver a high standard of patient care, be committed to patient needs and be transparent and accountable to them. Staff we spoke with understood the vision and said they felt the practice delivered high quality care, promoted good outcomes for patients and continually tried to make improvements. We found staff were clear about their responsibilities in relation to providing good care at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff we spoke with confirmed they had read the key policies such as safeguarding, health and safety and infection control. All five policies and procedures we looked at had been reviewed annually and were up to date.

We were told the practice held weekly governance meetings which were attended by the partners and the practice manager. We looked at minutes from the last two meetings and found that performance, quality and risks, complaints had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. However we noted the QOF report from 2012-2013 showed the practice scored 984 out of 1000. and QOF information for 2013-2014 indicated the practice had not maintained this level of achievement scoring 637 out of 900, which was still 3.2 points above the CCG average. We discussed this with the practice and were told this was due to some GP locums not picking up QOF issues and/or completing appropriate paperwork. The practice manager was now taking the lead for QOF and showed us evidence that the points for this year had increased. We saw QOF data was regularly reviewed and discussed at the practices weekly meetings. The practice also participated in local benchmarking run by the CCG.

The practice had completed a number of clinical audit cycles, for example we saw they had carried out an audit of patients prescribed high cost statins and identify review all patients who could be switched to another medication in line with the NICE guidelines. Of the 31 patients identified, 5 was already using the recommended drug, 9 patients could not be switched due to the medical conditions. 17 patients were therefore reviewed and changes made to the medication. The re-audit found that the new drug was as effective at controlling the medical conditions of some patients, however there were patients who had to be changed back to original medication.

The practice had robust arrangements in place for identifying, recording and managing risks. Identified risks were included on a risk log maintained by the practice manager with clear actions required and date to be completed clearly noted. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Leadership, openness and transparency

There were named members of staff in lead roles. All members of staff we spoke with were clear about their own roles and responsibilities and knew who the leads for all areas were. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They felt they worked well together and that they were aware of their areas of weakness such as the need to improve their cervical screening take up. Staff said the leadership team were always open to suggestions.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, For example, the recruitment and qualification checking procedure which was up to date. We were shown the staff handbook which was available to all staff.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active patient participation group (PPG) which met quarterly. Information about the PPG was available on the practice website. The PPG included

Are services well-led?

Good

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

representatives from various population groups including, older people, carers and patients from different ethnic and cultural backgrounds. The practice felt that the group was representative of the practice patients. Meetings were held quarterly and either a GP or the practice manager attended. We were shown minutes of meetings held in 2014 and saw that they had discussed having a TV in the waiting room showing health information and light entertainment. We were told minutes were distributed to members and displayed on notice boards in the waiting rooms on the website.

The practice had gathered feedback from patients through PPG patient surveys and complaints received. We looked at the results of the in-house annual patient survey from 2014 and saw that one area reviewed was patient's dissatisfaction was the amount of daily appointments available to see a GP. As a result the practice had employed another salaried GP.

Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy and the process to follow if they had any concerns.

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. We looked at staff files and saw that most annual appraisals were up to date. Appraisals included a personal development plan and staff told us that the practice was very supportive of training.

The practice scheduled meetings for the whole staff team, clinical and non-clinical. We saw from the minutes of meetings that they discussed where improvements to the service could be made.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings to ensure the practice improved outcomes for patients.