The Saluja Clinic

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 an announced comprehensive inspection at the Saluja Clinic on 15 August 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There were mixed findings from the national GP patient survey and the practice's own feedback exercises. Patients who participated in the inspection consistently said they were treated with compassion and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice received mixed patient feedback about the ease of making an appointment. Urgent appointments were available the same day and non urgent appointments were available in around a week. The practice had taken action to improve the patient experience of making an appointment and access to the service.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

Summary of findings

- The practice should review its exception reporting rates for cervical screening which are relatively high and investigate whether it could do more to reduce these.
- The practice should actively encourage eligible patients to attend for breast and bowel screening.
- The practice should improve the use of clinical audit to drive improvement and investigate topics of particular relevance to the practice.
- The practice should take steps to reduce the risk of the vaccines fridge being accidentally unplugged.
- The practice should continue to explore ways to improve patient satisfaction with the service and access to the service.
- The practice should review the sustainability of its current staffing structure and work patterns.
- The practice should actively seek to increase the number of identified carers to ensure they have access to appropriate support.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

The practice is rated as good for providing effective services.

Good

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average with the practice achieving 100% of available points.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice provided education and lifestyle advice and preventive care. However breast and bowel cancer screening rates were relatively low.

Are services caring?

The practice is rated as good for providing caring services.

Good

- Data from the national GP patient survey showed patients tended to rate the practice below the local and national average for several aspects of care. The practice's own surveys and patient feedback were more positive.

Summary of findings

- Patients who participated in the inspection said they were treated with compassion and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- We received mixed views from patients about the ease of making an appointment. The practice had recently introduced a telephone triage system and increased the number of sessions offered by a female GP to improve access. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and action taken to improve.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care in a welcoming environment. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. We were not fully assured however that the current staffing structure, which relied on the partners working long hours, was sustainable in the longer term.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and regularly carried out home visits and had an 'open door' policy for older patients some of whom were unfamiliar with appointment systems. The practice facilitated urgent appointments for those with enhanced needs.
- The practice provided the seasonal flu vaccination for patients over 65 and the shingles and pneumococcal vaccinations for eligible older patients.
- We received feedback from patients commenting on how well the staff treated older patients, for example, building a relationship and taking time during consultations.

People with long term conditions

Good

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

- The practice achieved a Quality and Outcomes Framework score of 100% in 2015/16. It kept registers of patients with long term conditions. These patients had a structured annual review to check their health and medicines needs were being met.
- The practice operated call-recall systems to encourage patients with long-term conditions to attend for their review. Nursing staff had lead roles in chronic disease management.
- The practice was performing well for indicators of chronic disease management. For example, the percentage of diabetic patients whose blood sugar levels were adequately controlled was 83% compared to the clinical commissioning group and national average of 78%.
- Patients identified as at risk were reviewed had a personalised care plan. Cases were discussed at regular multidisciplinary meetings.
- Patients with complex conditions were identified as a priority on the electronic record system and were able to book same day appointments, longer appointments and home visits when required.

Summary of findings

Families, children and young people

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

Good

- There were systems in place 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 A&E attendances.
- Immunisation rates were relatively high, for example 90% of children had received the standard recommended vaccinations by the age of one in 2015/16.
- 82% of patients with asthma had a review of their condition within the last year compared to the national average of 76%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. The practice prioritised younger children for same day appointments and sought advice from the local rapid access paediatric on-call consultant when appropriate to assess concerns and reassure parents.
- We saw positive examples of joint working with health visitors.

Working age people (including those recently retired and students)

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

Good

- 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.
- For example, the practice operated a telephone triage system and telephone consultations with a GP for patients who did not need a face to face consultation. The GPs were also able to send relevant information leaflets by text message to patients' mobile telephones.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice cervical screening coverage rate was 82% which was in line with the national average of 81%. However practice exception rate reporting was unusually high for this indicator at 25%.

Summary of findings

People whose circumstances may make them vulnerable

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

Good

- The practice held a register of patients living in vulnerable circumstances including homeless people, and patients with a learning disability or lacking mental capacity to make decisions about their care.
- The practice had a relatively high number of registered homeless patients who were signposted to the practice by local homeless organisations and workers.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care and social services professionals in the case management or referral of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations and were able to give us examples of positive ongoing support provided to patients in this position.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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

Good

- 100% (16 of 16) patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was above the national average of 84%.
- 97% (of 72) patients diagnosed with a psychosis had a comprehensive care plan recorded in their records compared to the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health.
- For example, the local mental health team outreach service attended the practice regularly to support existing patients, carry out case reviews and provide a rapid assessment for patients presenting with new symptoms.
- The practice provided information for patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia and manage risk, for example through 'safety netting'.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice received mixed results compared to the local and national averages with questions on access scoring below average. The survey programme distributed 374 questionnaires by post and 84 were returned. This represented 1% of the practice's patient list (and a response rate of 22%).

- 51% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 69% and the national average of 73%.
- 72% of patients were satisfied with the practice opening hours compared to the CCG average of 72% and the national average of 76%.
- 59% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 79% and the national average of 85%.
- 67% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 72% of patients described the overall experience of this GP practice as good compared to the CCG average of 78% and the national average of 85%.

We spoke with seven patients during the inspection including three members of the patient participation group and received 38 completed patient comment cards.

Patients who participated in the inspection were very positive about the practice, for example frequently describing the service as excellent and, in contrast to the national patient survey, all told us the clinical staff were kind and caring with several giving us their own examples of how the GPs and nursing staff had gone out of their way to be helpful.

There was some consistent criticism however about the appointment system which was also reflected in the national patient survey results. Eight of the 38 comment cards we received included a comment about the difficulty in booking a timely appointment.

The practice had an active patient participation group and members told us the practice was responsive to suggestions and had made improvements as a result of patient feedback, for example, recently increasing the number of sessions offered by a female GP and increasing the number of receptionists available to answer the telephone at busy times of day.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The practice should review its exception reporting rates for cervical screening which are relatively high and investigate whether it could do more to reduce these.
- The practice should actively encourage eligible patients to attend for breast and bowel screening.
- The practice should improve the use of clinical audit to drive improvement and investigate topics of particular relevance to the practice.
- The practice should take steps to reduce the risk of the vaccines fridge being accidentally unplugged.
- The practice should continue to explore ways to improve patient satisfaction with the service and access to the service.
- The practice should review the sustainability of its current staffing structure and work patterns.
- The practice should actively seek to increase the number of identified carers to ensure they have access to appropriate support.

The Saluja Clinic

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team included a GP specialist adviser.

Background to The Saluja Clinic

The Saluja Clinic provides NHS primary medical services to around 9500 patients in Southall in the Ealing borough of west London. The service is provided through a general medical services contract. The practice is located in modern purpose built premises.

The current practice clinical team comprises two GP partners, and two salaried GPs. The GPs typically provide around 28 sessions in total each week. The practice employs two part-time practice nurses (one whole time equivalent) and a health care assistant. The practice has a financial partner and also employs a practice manager and administrative and reception staff. Patients have the choice of seeing a male or female GP.

The practice is open from 8am-6.30pm Monday to Friday and from 9am-1pm every Saturday. The practice offers online appointment booking and an electronic prescription service. Same day and longer appointments are available for patients with complex or more urgent needs. The GPs make home visits to see patients who are housebound or are too ill to visit the practice.

When the practice is closed, patients are advised to use a contracted out-of-hours primary care service if they need urgent primary medical care. The practice provides information about its opening times and how to access urgent and out-of-hours services in the practice leaflet, on its website and on a recorded telephone message.

The practice population age profile is younger than the English national average with a relatively high proportion of adults aged 20-39 years. The practice catchment area is characterised by higher than average unemployment rates and areas of poor housing stock with associated health problems. The practice population is ethnically and culturally diverse with a majority being of Indian, Pakistani or Bangladeshi heritage. The practice population includes patients who have recently come to the UK with complex health needs including mental health problems associated with trauma.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder and injury. The practice has not previously been inspected by CQC.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 August 2016. During our visit we:

- Spoke with a range of staff including the GP partners, the practice nurse, the health care assistant, the practice manager and receptionists.
- Observed how patients were greeted at reception.
- Inspected the facilities, environment and equipment.
- We spoke with seven patients including three members of the patient participation group.
- Reviewed 38 comment cards where patients shared their views and experiences of the service.
- Reviewed a sample of the treatment records or care plans of patients. We needed to do this to understand how the practice was involving patients and carers in decisions and to check it was carrying out health checks and medicine reviews in line with its policies.
- Reviewed a range of documentary sources of evidence including practice policies, protocols, audits, meeting minutes and monitoring checks.

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

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

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

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

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

Good

Are services safe?

Our findings

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available to all staff on the practice's computer system. The practice risk assessed incidents and the incident reporting form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of significant events and shared information and learning arising from significant events more widely when appropriate. For example the practice alerted the relevant healthcare provider when one of their patients had been inappropriately discharged.

We reviewed safety records, incident reports and patient safety alerts. The practice kept a log of significant events, critical incidents, near misses and relevant alerts.

Significant events were discussed at staff and clinical meetings and the minutes circulated to members of staff unable to be present and retained for future reference. We were told that incident reporting was encouraged. The practice had reported 22 incidents over the previous year and incidents had been reported by doctors, nurses and the administrative team. The practice recognised good practice when reviewing incidents as well as identifying areas for improvement.

We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a prescribing error, the practice had increased its use of electronic prescribing and read coding which provided additional checks that prescribing was appropriate.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice had designated leads for safeguarding children and vulnerable adults. The GPs provided safeguarding related reports where necessary for other statutory agencies.
- Staff demonstrated they understood their responsibilities and all staff (including the administrative staff), had received training on safeguarding children and vulnerable adults relevant to their role. We saw examples, where staff had raised concerns about the safety of patients and these had been followed up in line with local procedures. The GPs and practice nurses were trained to child safeguarding level 3. All other staff were trained to level 1.
- Notices in the waiting and consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the GP partners was the lead for infection control in the practice and the practice nurses were responsible for monitoring infection control practice day to day. The practice had comprehensive infection control policies in place including hand washing, handling of specimens and handling of 'sharps'. Staff had received up to date training. The practice also carried out in-house annual infection control audits. The most recent audit had identified several actions for improvement, for example the replacement of a curtain and new seating in the waiting room. These recommendations had all been implemented.
- The practice had effective arrangements for managing medicines safely (including obtaining, prescribing,

recording, handling, storing, security and disposal of medicine). Processes were in place for handling repeat prescriptions which included the review of high risk medicines and regular review of patients on long-term prescriptions. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- The practice had systems in place to keep prescription materials secure, for example in locked rooms. The practice did not use paper prescription pads or keep prescription materials in doctors' bags.
- The practice had a 'cold chain policy' and systems in place to ensure vaccines and any other medicines were stored at the appropriate temperature. The practice nurse and health care assistant monitored fridge temperatures in line with current guidelines and kept records of daily checks. The vaccines fridge had a standard removable plug but the practice had not added any warning to remind staff that the fridge should not be unplugged.
- Patient group directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- The practice used patient specific directions (PSDs)to enable the health care assistant to give flu vaccinations. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Most risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had appropriate health and safety policies and protocols in place with named leads. The practice premises had been risk assessed for fire safety. The practice carried out regular fire drills and had an evacuation plan. The practice had recently experienced a fire and all staff and patients had been evacuated promptly. The fire brigade had subsequently checked the practice's fire safety arrangements and found these met all requirements.
- All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. The property management agency had risk assessments in place to monitor safety such as control of substances hazardous to health; infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice kept and was able to provide copies of environmental risk assessments.
- Arrangements were in place for planning and monitoring the number of staff needed to meet patients' needs. There was a rota system in place to ensure enough staff were on duty with the appropriate skill mix. The practice obtained locum doctors when required and had hired an agency phlebotomist at the time of the inspection.
- The practice had systems in place to ensure that test results and urgent referrals were actioned, including a process to follow-up patients that had 'two-week' cancer referral appointments.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- There were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and child masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

Good

Are services safe?

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
- The practice had experienced medical emergencies the previous year and had reviewed these as significant events and for example, reviewed the emergency medicines list and training as a result. Emergencies had been handled in line with practice policy.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and local 'pathways' agreed by the clinical commissioning group (CCG) and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that guidelines were followed through group discussion, audits, medicines reviews with individual patients and checks of patient records. The practice was able to show us examples of audits against NICE guidelines, for example, a recent prescribing audit of the management of patients with atrial fibrillation.
- Clinicians utilised standardised templates within the electronic patient record system for care planning and reviews of long term conditions which incorporated good practice guidelines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2015/16 were 100% of the total number of points available compared to the clinical commissioning group average (CCG) of 95.7% and the national average of 95.3%. The practice tended to have similar exception reporting rates to the CCG average, for example exception reporting was at 8.2% for the clinical domain compared to the CCG average of 10.9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- The prevalence of diabetes was high locally. Eleven per cent of the practice population had been diagnosed with diabetes. Practice performance for diabetes related indicators was above the local and national averages. For example, 83% of diabetic patients had blood sugar levels that were adequately controlled (that is, their most recent IFCC-HbA1c was 64 mmol/mol or less) compared to the CCG average of 76% and the national average of 78%. Seventy-eight per cent of practice diabetic patients had a recent blood pressure reading in the normal range compared to the CCG average of 76% and the national average of 78%. The practice's exception reporting rates for diabetes indicators were lower than average.
- The practice provided a wide range of information for patients about diabetes. All newly diagnosed patients were referred to a structured education course about the condition and how to manage it.
- In 2015/16, 100% (of 16) patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, compared to the national average of 84%.
- For patients with a diagnosis of psychosis, 97% had an agreed, comprehensive care plan compared to the national average of 89%.

There was evidence of quality improvement including clinical audit.

- The practice used clinical audit as a tool to monitor and improve its performance and had developed a standard template to record individual audit projects and the results. The practice had completed multiple clinical audits over the last two years, several of which were ongoing audits where improvements were monitored annually. Relatively few of the practice-initiated audits were completed two-stage audits where changes had been implemented and then reaudited to ensure improvement had been sustained. Topics included the prescribing of protein pump inhibitors, falls, and medication reviews. The latter had been prompted by a significant incident.
- Clinical audits were prompted by CCG or locality prescribing priorities. For example, the practice had carried out a completed two-cycle audit assessing the suitability of patients prescribed modified-release quetiapine to change to an immediate release form of the medicine in line with CCG prescribing

policy. Following the initial audit, a number of patients' prescriptions were changed. The re-audit showed that all patients were on the appropriate form of quetiapine for their particular condition.

- The practice participated in locality based audits and national benchmarking. The clinical staff also told us they were able to discuss and share findings at locality meetings although these discussions were not formally recorded.
- Findings were used by the practice to improve services. For example as a result of comparative performance data it had focused on reducing its antibiotic prescribing and investigating the relatively low prevalence of chronic obstructive pulmonary disease (COPD) in the practice population. As a result the practice was now one of the lower antibiotic prescribing practices in the CCG (although there seemed to be some variation in prescribing levels within the practice). It had introduced in-house spirometry testing to more accurately assess patients presenting with symptoms of COPD.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had a structured induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, training, reference to written guidelines and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on going support, one-to-one meetings, team meetings and informal discussion and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. Where performance issues were identified, these were addressed in line with the relevant practice policies.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and the shared computer drive.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

The practice participated in the local integrated care programme aiming to avoid unnecessary hospital admissions for patients assessed to be at high risk. Practice clinicians attended multidisciplinary meetings in the locality at which care plans were routinely reviewed and updated for patients with complex needs. The practice also routinely liaised with health visitors, district nurses and the local palliative care team to coordinate care and share information. The practice had access to a local care coordinator who was able to signpost patients to local community resources.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. All staff had also received training on their responsibilities under the Mental Capacity Act.

Good

Are services effective?

(for example, treatment is effective)

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.

The practice had systems in place to ensure that where patients had made advance decisions, these were communicated to other services when necessary, for example, to the ambulance service if attending out of hours.

Supporting patients to live healthier lives

The practice identified patients in need of extra support. For example: patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

In 2015/16, the practice uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 79% and the national average of 81%. However, the practice exception reporting rate was higher than average at 25%. The practice ensured a female sample taker was available. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also sent invitations to eligible patients to attend national screening programmes for bowel and breast cancer screening. Uptake and coverage rates were low. In 2015/16, the coverage for breast cancer screening was 49% which was below the CCG average of 66%. Bowel cancer screening coverage was 28% compared to the CCG average of 46%. The practice told us that screening was poorly understood among some sections of the practice population with a further complication that many patients travelled abroad for part of the year. This remains an area for improvement.

Childhood immunisation rates were in line with the local average although just below the 90% target in 2015/16. For example at the time of the inspection, 89% of eligible babies had received all standard vaccinations by the age of one year.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The staff carrying out health checks were clear about risk factors requiring further follow-up by a GP.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were polite and helpful to patients and treated them with respect.

- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The reception was located away from the main patient seating area. Reception staff were able to take patients to a more private area if they needed to discuss sensitive issues or appeared distressed.

The practice partners told us they aimed to be a caring service and treat patients like 'family'. Patients who participated in the inspection were very positive about the practice, said they developed good, trusting relationships with their doctors and frequently describing the service as excellent. Patients told us the clinical staff were kind and caring with several, giving us examples of how the GPs and nursing staff had gone out of their way to be helpful. In one case we were told how the GPs long-term support had been life-changing.

Results from the national GP patient survey showed that the majority of patients felt they were treated with compassion, dignity and respect. However, the practice tended to score below the local and national averages for satisfaction scores on consultations with GPs and nurses. For example:

- 75% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 68% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 67% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 74% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 82% and the national average of 91%.
- 64% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

The practice had carried out its own patient surveys in previous years with higher response rates which were more positive about patients' experience of consultations. The practice also invited patients to participate in the national 'Friends and family' survey. The most recent results showed that 70% of patients would recommend the practice to others.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

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. The practice tended to score below the local and national averages although these differences were not statistically significant. For example:

- 70% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%.
- 68% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and the national average of 82%.
- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 85%.

The practice supported patients to be involved in decisions about their care:

- Members of the practice team were able to speak a number of locally spoken languages which facilitated good communication.

Good

Are services caring?

- Staff told us that translation services were also available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Some patients told us they had received good emotional support from their GP during difficult times or situations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 34 patients as carers (less than 1% of the practice list). The practice had started to proactively ask patients (for example on registration) if they were a carer but had not yet found ways to address a cultural stigma around the issue. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if patients had suffered bereavement, their usual GP wrote to them and offered a consultation. The practice could give these patients advice on how to find a bereavement support service. We were given an example by a patient of very good emotional support over a sustained period following a bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) and other practices in the locality to secure improvements to services where these were identified. For example, the practice provided a range of 'enhanced' services (such as phlebotomy, spirometry and complex wound dressings) to reduce the need for patients to travel to hospital outpatient clinics.

- The practice offered appointments until 6:30pm for patients who found it difficult to attend during normal opening hours. The practice also opened for patient health checks every Saturday morning. During busy times of year, the GPs also provided surgery hours and the practice offered seasonal flu vaccination clinics on Saturday mornings.
- There were longer appointments available for patients with a learning disability or other complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with more urgent medical problems.
- Patients were able to receive travel vaccinations. The practice informed patients in advance which vaccinations were available free on the NHS and about any which were available only on a private prescription basis and the associated fees.
- The service was accessible to patients with disabilities and a translation service was available. The practice had a hearing induction loop, accessible toilet and baby changing facilities.
- The practice had a relatively high proportion of patients with complex needs, mental health problems and patients whose circumstances may make them vulnerable. For example, it had retained links with a community of travellers, most of whom had chosen to remain registered at the practice despite being outside the current catchment area. The practice also had a number of patients who were homeless, who had registered through word of mouth recommendation. The practice partners told us the practice had an ethos of providing fair and accessible primary care regardless of patients' personal circumstances.

Access to the service

The practice was open from 8am until 6.30pm during the week and from 9am until 1pm on Saturday. Morning appointments were available from 8:30am and afternoon appointments until 6.30pm. Same day appointments were available for patients with complex or more urgent needs. The practice offered online appointment booking and an electronic prescription service.

Results from the national GP patient survey showed that patient satisfaction with access to the service was below the local and national averages for satisfaction with access to the service:

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and the national average of 76%.
- 51% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% and the national average of 73%.
- 59% of patients said they were able to book an appointment to see or speak to a GP or nurse compared to the CCG average of 79% and the national average of 85%.
- 51% of patients described their experience of making an appointment as good compared to the CCG average of 67% and the national average of 73%

This was a theme in the patient comment cards we received. Seven of 38 patients commented that although other aspects of the service were good, they sometimes struggled to get a timely appointment. The people we spoke with on the inspection told us that they had obtained appointments easily. We also reviewed the practice appointment system and found that routine appointments to see the next available doctor or nurse were available within one week and this seemed to be typical.

The practice had recently taken a number of steps to improve access. It had introduced a telephone triage system, so that if patients rang for a non-urgent appointment, the duty doctor would ring back to assess whether they needed a face to face appointment or would

Good

Are services responsive to people's needs?

(for example, to feedback?)

provide a telephone consultation or signpost the patient to another service, for example the pharmacy's minor illness service. The practice had also increased the number of receptionists to answer the telephones at busy times.

The patient participation group members told us they had discussed the issue of access. The group had suggested that the number of sessions offered by a female GP be increased and this had been implemented. They had also suggested the practice install an additional telephone line but were not sure if this was going to be implemented. The group members told us they thought that access was improving.

The practice had a system in place to assess:

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

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

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The practice had a written complaints leaflet and had designed a clear poster on how to make a complaint which was put on display in the waiting area.

The practice had received 23 complaints or negative comments in the last 12 months. The practice logged written and verbal complaints and comments posted on public websites for review and learning. Most complaints in the previous year were about difficulty making an appointment, or communication errors or misunderstandings with the reception staff.

These were responded to and investigated in line with the practice's complaints policy. The practice learnt from individual concerns and complaints and discussed patient feedback at practice meetings. For example reviewing relevant protocols with staff and providing additional customer service training for the reception team.

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 aims were to provide high quality, patient centred care in friendly and welcoming environment. The practice was also keen to make use of innovation and technology to improve efficiency.

- Patients we spoke with and staff consistently told us the practice provided a good service to the local community.
- The practice had a strategy and supporting business plans which reflected the practice goals.

Governance arrangements

The practice had a governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained through the Quality and Outcomes Framework (QOF) and other measures. The practice had changed the way it monitored QOF for example, to take account of patients' travel arrangements and the practice performance had improved over recent years.
- The practice generally performed well but we noted that exception reporting was high for cervical screening coverage. The practice had not investigated the reasons for this and whether it could take further action to reduce exceptions (for example, the number of women refusing the test).
- The practice carried out audits to monitor quality and to make improvements. However, it did not develop its own audit programme related to practice priorities but reacted to local commissioning priorities. The practice could do more to embed clinical audit as a driver for improvement.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had effective safeguarding procedures in place and acted to protect patients at potential risk of abuse.

The provider had an effective procedure to manage significant events within the practice which included a risk assessment. Staff were aware of the procedures and the importance of being open with patients in line with the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice had systems in place to ensure that when things went wrong with care and treatment:

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

Leadership and culture

The practice partners demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us the partners and practice managers were approachable and accessible.

The practice provided 28 clinical GP sessions per week for a practice population of 9500 patients which seemed relatively low. However, we found that these sessions were frequently extended and both partners routinely worked long hours at the practice. The partners had carried out longer term planning and had given some consideration for example, to succession but had not seriously reviewed the sustainability of the current staffing structure and working patterns.

There was a clear leadership structure in place and staff said they were supported by the practice manager and their colleagues.

- The practice held regular team meetings and kept minutes of the discussion and any action points.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at any time.
- Staff had annual appraisals which included consideration of their personal development needs and aspirations.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Good

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team.
- The PPG were very positive about the willingness of the practice to listen to feedback and take action. For example, the group told us about action the practice had taken to improve patient access and the practice environment.
- The practice had gathered feedback from staff through practice meetings, appraisals and informal discussion.
- Staff we interviewed were aware of the whistleblowing procedure.

Continuous improvement

The practice was keen to improve. We saw evidence that the practice had acted on areas where it had been performing comparatively poorly, for example antibiotic prescribing and patient access. The practice had steadily improved its QOF performance and had attained 100% overall in 2015/16.

- The practice participated in local schemes to improve outcomes for patients, for example identifying patients at risk of unplanned hospital admission and proactively case managing their care.
- The practice had plans to expand the building to enable it to increase the number of consultation rooms and substantially increase its capacity and also the range of clinical services it could offer.