Dr Z Ahmad & Partners

Quality Report

Gardenia & Marsh Farm Practice
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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 visited Gardenia Practice on the 19 November 2014 and carried out a comprehensive inspection.

The overall rating for this practice is good.

The practice had a branch surgery at Marsh Farm Practice, but this was not inspected.

Our key findings were as follows:

- Patients reported that doctors and the nurse were caring and thorough. The felt they were treated with kindness, dignity and respect.
- There were systems in place to provide a safe, responsive, caring and well-run service although some improvements were required to demonstrate effective care was being delivered.
- The practice had engaged well with patients and had an active patient participation group who represented the views of the practice population.
- The practice demonstrated it had an open and honest culture with systems in place to ensure that they learnt from when things went wrong.

The practice had recently undergone management changes with a change of leadership and a new practice manager. They demonstrated that they had a vision for the practice and were starting to develop plans in how they would achieve their vision, but this was in its early stages. Therefore, the practice should continue to develop and implement this, which would enable them to improve outcomes.

Whilst the overall rating was good, there were some areas which required improvement. The practice should address the following:

- Continue the work they have started to improve their approach to disease management and the development of more robust systems in this area, specifically regarding management of long term conditions.
- Expand the business continuity plan to included detail of how they would access doctors and nurses in an emergency.

Summary of findings

- Ensure that a fire drill is carried out as soon as possible and that there is a system in place to ensure they are carried out at regular intervals thereafter.
- Ensure that actions from the fire risk assessment are completed and documented.
- Appraisals should be completed with all staff when appraisal training has been undertaken by the practice manager and a schedule of appraisals should be produced to ensure this continues.
- Ensure that all risks are managed, monitored and appropriate mitigating actions taken.
- Produce a clear strategic development plan to demonstrate how the vision is to be achieved and provide clear direction to staff in order to improve effectiveness.

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 safe. 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. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services overall. However, data showed patient outcomes were below average for the locality and nationally for several clinical areas such as diabetes although we saw that the practice was developing plans to address this. NICE guidance is referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff have received training appropriate to their roles but the practice still needs to carry out all appraisals for this year and produce personal development plans for all staff. However, there was evidence that this will be carried out when training in appraisal is completed. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. 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. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

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 the NHS England Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was 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.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. They demonstrated that they had a clear vision and strategy to deliver this but this was not documented. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions and attended staff meetings and events although appraisals were still awaiting completion as the practice manager was new in post. However, there was evidence that this was being addressed and would be completed within an appropriate timescale.

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. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice had acknowledged that there were some areas where robust systems had not been in place regarding long term conditions such as diabetes and demonstrated that they had started putting in plans to address these. Therefore, it is anticipated that the outcomes of this work will be evident in six months to a year.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-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 all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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).

Summary of findings

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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

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 learning disabilities. They had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND and SANE. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We reviewed comment cards that had been left by patients at the practice. Three cards had been left and the comments were positive and expressed satisfaction with the doctors and caring and helpful staff. Patients commented on improvements in the service reporting improved access to appointments and easier access via the telephone since the introduction of the new telephone number.

We spoke with six patients during our inspection. All patients told us that they received good care from the practice. Some patients commented that the doctors were very thorough and offered other treatments during their consultation, for example a pneumonia vaccination when they had attended for their flu vaccine.

Two patients reported satisfaction at being able to be seen on the day when they had experienced sudden illness. Other patients told us that they had experienced prompt appropriate referral to secondary care when they needed it.

Areas for improvement

Action the service SHOULD take to improve

- The practice should continue to progress with the work they have started to improve their approach to disease management and the development of more robust systems in this area, specifically regarding management of long term conditions.
- The business continuity plan should be expanded to included detail of how they would access doctors and nurses in an emergency.
- The practice should ensure that a fire drill is carried out as soon as possible and that there is a system in place to ensure they are carried out at regular intervals thereafter.
- The practice should ensure that actions from the fire risk assessment were completed and documented.
- Appraisals should be completed with all staff when appraisal training has been undertaken by the practice manager and a schedule of appraisals should be produced to ensure this continues.
- The practice should ensure that all risks are managed, monitored and mitigated.
- A clear strategic development plan should be produced to demonstrate how the vision was to be achieved and provide clear direction to staff in order to improve effectiveness.

Dr Z Ahmad & 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, another CQC inspector and the CQC Regional GP advisor.

Background to Dr Z Ahmad & Partners

The practice covers an area near the centre of Luton and provides primary medical services for approximately 10,800 patients. There are a high number of eastern European patients registered with the practice and a higher than average number of patients of working age. There are three registered partners and currently four locum GPs who work regularly covering 14 sessions in a week at the practice. There is one practice nurse, and one health care assistant, a practice manager who is supported by administrative and reception staff. Since our inspection the practice have notified us that a new nurse has been employed.

The practice has a branch surgery located at Marsh Farm Health Centre, The Purley Centre, Luton. This was not inspected as part of this inspection.

The practice provides medical services under a General Medical Services (GMS) contract. They participate in the Quality and Outcomes Framework (QOF) and a variety of enhanced services, such as dementia and prevention of unplanned admission to hospital. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care. The practice have performed below the CCG and England average in some areas of QOF disease management and are exploring and planning ways of addressing this.

Out of hours care is delivered through the NHS 111 service when the surgery is closed.

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. This 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.

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.

How we carried out this inspection

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 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

Detailed findings

- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

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 inspection on 19 November 2014. During our inspection we spoke with a range of staff including, GPs, a nurse, practice manager, reception and administrative staff and we spoke with patients who used the service. We spoke with a representative of the patient participation group, reviewed comment cards where patients and members of the public 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 quality in relation to patient safety. National safety alerts were received and disseminated by the practice manager and the senior partner. These were discussed with clinicians and relevant staff if they considered further action was required.

Staff told us that all incidents were reported to the practice manager who collated and logged them and showed the actions that had been taken. We saw the log of incident reports and minutes of meetings where these were discussed. Staff we spoke with demonstrated an awareness of their responsibilities to raise concerns and the procedure to do this. For example, one member of the clinical staff described an event regarding out of date medication, which they had reported and had prompted a review and a change in the process of checking the expiry of medicines to prevent a recurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Significant events were not a specific agenda item at monthly practice meetings, however, we saw evidence that appropriate learning had taken place and that the findings had been disseminated to relevant staff. For example, we saw that when a significant event had occurred and been logged, it had been discussed at the next practice meeting. We saw minutes of the practice meeting which confirmed this. Significant events were reviewed every six months and discussed at a practice meeting and shared with staff, which demonstrated that they had been analysed, actioned and outcomes or changes in practice had been shared with staff.

We saw that standard incident forms were in use and these were kept in a specific significant event file together with information regarding the events. We tracked eight significant events and saw records had been completed in a comprehensive and timely manner and appropriate actions had been taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw staff training records that showed all staff had received relevant role specific training on safeguarding. For example, the doctors were trained in safeguarding at level 3 and other staff to level 2 which was appropriate. We spoke with doctors and other staff who confirmed their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We saw that safeguarding contact details were readily available for staff to view in various areas of the practice such as reception.

The practice had two dedicated GPs appointed as leads in safeguarding. One was responsible for safeguarding children and the other for safeguarding vulnerable adults. All staff we spoke to were aware of who the leads were and who to speak to in the practice if they had a safeguarding concern.

We saw that there was an electronic marker on the clinical record to alert staff to those patients who were at risk of abuse. Staff told us that there was good communication with health visitors and social services and information was shared using a software system called SystmOne. This was a common system used by many health care providers allowing information regarding patients to be shared with their permission.

A chaperone policy was in place and signs were visible around the practice informing patients that a chaperone was available. Chaperone training had been arranged for March 2015 to be undertaken during the practice protected learning session by the nurse, health care assistant and reception staff. However, they had not attended training at the time of inspection. The practice manager told us that it was usually the nursing staff that acted as a chaperone.

The practice nurse followed up children who did not attend for immunisations and had access to the health visitor if necessary to discuss failure to attend. The practice manager told us that when the practice were notified of a new birth, they sent out a card with information inviting the mother to register their baby with the practice.

Good

Are services safe?

Medicines Management

We checked vaccines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw records showing the daily recording of temperatures and that vaccines were rotated to ensure that none were at risk of becoming out of date. We checked a random sample of vaccines in the refrigerator and found that they were all in date and that the cold chain was being maintained.

We saw records of a practice meetings specifically designated to repeat prescribing. This covered a number of issues around that area, such as the reauthorizing of repeat prescriptions and ensuring a systematic approach. It also showed that the practice had reviewed, amended, agreed and adopted a new repeat prescribing policy. We saw that there was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw staff records that showed that the nurse had received appropriate training to administer vaccines.

There was a system in place for the management of high-risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. All prescriptions were reviewed and signed by a GP before they were given to the patient. We found that blank prescription forms for printing electronically were stored upstairs away from the public but were not in a locked cupboard. The practice were informed that these should be stored in a locked cupboard when not in use.

The doctors own prescription pads were kept securely in a locked cupboard but the practice did not record serial numbers and require signing for to provide a method of tracking prescriptions if necessary. The practice should ensure that they record the serial numbers enable prescriptions to be tracked if required. Since our inspection the practice manager has confirmed that blank prescription forms for printing have been removed and are now stored in a locked cupboard and a process has been put in place to record serial numbers of prescription pads for tracking purposes.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept and maintained which we saw back to 2011. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a clinical and a non-clinical lead for infection control. We looked at staff records which demonstrated that staff had undertaken infection control training. We saw that a recent infection control audit had been carried out which had identified some issues. The practice had addressed these in response to the audit. For example, they had replaced bins with pedestal bins and cleared floor space of rubbish.

An infection control policy was in place and staff were aware of it, but the practice were adopting the Bedfordshire & Luton Clinical Commissioning Group policy which was due to be approved at the December 2014 clinical meeting. Personal protective equipment including disposable gloves and aprons were available for staff and we observed during our inspection that staff used these when necessary. We noted that hand washing equipment was available in all room. There was also a policy for needle stick injury and staff were aware of it.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed that a Legionella assessment had been carried out in March 2013 but the practice could not produce evidence that all recommendations had been acted on. For example, the reference to temperature checks and other water related issues. The practice should ensure that a system is put in place to address this and it is documented. Since our inspection the practice has contacted us and informed us that a Legionella assessment has been arranged to be carried out on 29 January 2015.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments and we saw evidence of equipment available. They told us that all equipment was tested and maintained regularly and we saw equipment

maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing & Recruitment

We saw that a recruitment policy was in place and records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager told us that the mix of staff was historic and that they were adding new staff such as a salaried doctor and a practice nurse. We saw there was a rota system in place to determine adequate staffing and doctors covered each other when on annual leave. There was always a minimum of two doctors on duty at any one time. The practice used agency staff to cover when nurses were on annual leave.

We saw that there were enough staff to maintain the smooth running of the practice and there were sufficient staff on duty to ensure patients were kept safe. Since our inspection the practice informed us that they have now employed another practice nurse.

Monitoring Safety & 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was a GP who had been identified as the health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings. For example, we saw minutes of practice meeting in May 2014 which confirmed this and we saw the agenda for this to be discussed again at the meeting scheduled for December 2014. The risk log showed that all staff were up to date with cardio pulmonary resuscitation training.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients in care homes were allocated a specific GP and those patients were visited at the care home by their named GP to provide continuity of care and enable the GP to be aware of the patient's history. The practice were proactive in preventing unplanned admissions or readmission to hospital by using care plans for those patients who frequently attended hospital, for example those patients with complex long term conditions.

Staff we spoke with told us that requests for medical problems with babies and young children were always directed to the doctor or nurse for advice or to determine the need for an appointment. They were also trained to know when to direct the patients immediately to hospital for example, chest pain or severe bleeding and were able to demonstrate this. We saw a laminated poster containing guidance for staff in the reception area to evidence this.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available and all staff we asked knew the location of this equipment and records we saw confirmed these were checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were in place to check emergency medicines were within their expiry date and suitable for use and we checked the medicines during our inspection and found they were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was identified and mitigating actions recorded to reduce and manage the risk although no rating was given to the risk. Risks identified included power failure, heating failure and water failure. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. The document also referred to accessing doctors and nurses in an emergency but there was no detail to demonstrate how this would happen. The practice should expand the plan to demonstrate this.

Good

Are services safe?

Fire alarm systems had been checked by a qualified contractor and a certificate was seen to confirm this. A fire risk assessment had been undertaken that included actions required to maintain fire safety. However, there was no documentary evidence that the actions had been completed. The practice should ensure that these are completed and documented. We saw records that showed staff were up to date with fire training but there was no evidence of a recent fire drill. The practice manager told us they were currently arranging this. The practice manager was new in post and was in the process of prioritising and updating all procedures and processes in the practice.

Risks associated with service and staffing changes were required to be included on the practice risk log. The practice was experiencing on-going recruitment issues for both nurses and GPs and was managing these through locums and agency staff. However, these were not on the risk log. The practice should ensure that these are added to the risk log to demonstrate these mitigating actions.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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 accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. However, the GPs and nurse we spoke with were aware of unmet needs for some of the practice population. This was due to a specific area of high deprivation and patients whose first language was not English and where compliance with screening and treatment for long-term conditions were not good. This had resulted in lower than the CCG and National average achievement in the Quality and Outcomes Framework for conditions such as diabetes and blood pressure recording, and mental health. They had also acknowledged that a more systematic approach to chronic disease management such as diabetes was required to improve outcomes for patients. They had identified that diabetes was an area that required focus and had nominated a GP lead for the practice to develop a more effective approach to achieve better outcomes for patients.

At the time of our inspection, some areas of achievement in disease management showed that they were not in line with similar practices in the CCG and indicated some improvement was required. We noted that work had commenced to address this from evidence that the practice had been actively trying to recruit a new nurse, allocating lead clinicians to be responsible and making changes to clinics to improve uptake. For example, they had changed the child immunisation clinic to co-inside with market day in the town. The GPs and staff demonstrated a commitment to address this work and the approach they had planned assured us that this work would develop and continue. Since our inspection the practice manager has confirmed the successful recruitment of a practice nurse.

The lead GP had arranged additional training and was organising in house training for the practice to support work in this area. The practice nurse demonstrated knowledge regarding diabetes and worked with the GPs to monitor and support patients with diabetes in line with national guidance. There was evidence of referral to educational support groups such as the Diabetes Education and Self-Management for On-going and Newly Diagnosed (DESMOND).

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcomes for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. We saw evidence that multi-disciplinary meetings took place for patients with complex palliative care needs and their needs were assessed thoroughly on a monthly basis and action points were identified and appropriately allocated.

The practice nurse carried out chronic disease management and a locum nurse attended to carry out a short term chronic disease clinic for patients suffering with chronic obstructive pulmonary disease (COPD). Clinical staff we spoke with told us they were able to ask colleagues for advice and support. For example, the nurse told us that they worked closely with the GPs and felt supported to continually review and manage patients' chronic conditions. We saw minutes from clinical meetings which showed an open and pro-active approach to health promotion and disease management. For example, how the seasonal flu vaccination programme would be managed to ensure all relevant patients were included. We also saw minutes showing that the practice planned to contact all patients by letter who had had an unplanned admission to hospital.

All GPs in the practice held their own list of patients with long-term conditions and the practice were looking at developing more effective ways of following up patients who did not attend. The GPs told us that discharge letters were read coded and directed to the relevant GP to action as appropriate. Each GP checked the discharge medicines against the current repeat medicines to ensure they were correct.

The practice engaged in peer review meetings with other practices in the clinical commissioning group (CCG) cluster and we saw evidence of review of cardiology, gynaecology and trauma and orthopaedic referrals and subsequent discussion at practice meetings.

Good

Are services effective?

(for example, treatment is effective)

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 referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The GPs were actively involved in chronic disease management as well as the practice nurse and they had identified that diabetes was a specific issue which needed addressing. The practice had agreed to standardise their approach to diabetes and this was starting to be addressed. For example, they had allocated a lead GP to be lead on diabetes and who had identified additional training which was to be undertaken. Discussions with the clinical staff demonstrated that the practice had a commitment to develop these areas further. There was also evidence that the practice had agreed actions with the NHS England area team and the local clinical commissioning group to address all areas where improvements could be made. We saw an action plan which had been produced and agreed by the practice which they confirmed they were working to. We saw that the practice had already completed some actions and to improve outcomes for patients. For example, they had identified that patients were not attending for retinal screening as it was held at a venue too far away, therefore they were now hosting it at the practice to try to improve uptake. They were also co-ordinating other areas of the diabetes review to be carried out at the same time as the retinal screening. The practice also used SMS messaging to remind patients of appointments which the practice manager confirmed had reduced the DNA rate.

We saw two clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit, for example, an improvement in recording of information regarding children presenting with childhood fever in response to review of NICE guidance. The practice had also undertaken an audit on anticoagulant therapy which had resulted in all relevant patients being reviewed and on the optimum medication and treatment.

The GPs told us clinical audits were often linked to medicines management information, or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

We saw minutes from a clinical meeting which referred to QOF outcomes and what action must be taken to facilitate improved outcomes and achievement. For example, we saw that coding of diabetes and blood pressure had been discussed and the importance of ensuring maximal therapy with explanations.

The practice had signed up to provide the enhanced service for patients with dementia which would ensure that these patients received annual review and that care plans were completed. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. They were aware that they were an outlier in diabetes and had been taking action to address this. For example, the practice were changing their approach to calling patients for review and ensuring that patients with multiple conditions were sent one appointment to review them all at one consultation.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The practice had also agreed to always check that during routine appointments that any outstanding necessary checks were also recorded such as weight and blood pressure.

Effective staffing

Practice staff 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, safeguarding and infection control. There were adequate levels of GP staffing as there were three full time partners and regular locum GPs, but the practice would benefit from more nursing staff as there was only one registered nurse. This was being addressed by the practice but they had experienced difficulty in recruiting a nurse. Following discussions with staff we found that the nurse was supported by the GPs and they always ensured that there was a GP available when the nurse was working. We saw from minutes of meetings that this had also been agreed by the clinicians. The practice had recently employed a new health care assistant who was being trained by the practice nurse. We also saw that comprehensive external training programme had been sourced for them to attend which included areas such as spirometry, women's and men's health, mental health and health screening.

All GPs were up to date with their yearly continuing professional development requirements and all either have

Good

Are services effective?

(for example, treatment is effective)

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 NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The practice manager was new in post and told us that they were undertaking training in appraisal in February 2015. They were developing a schedule of appraisal to complete after that date to ensure that they had the skills to carry out the task effectively. Staff we spoke with told us that they were supported in their role and felt they could request training and development at any time if they identified training needs.

The practice nurse had defined duties they were expected to perform and were able to demonstrate they were skilled to fulfil these duties. The nurse had undergone training in smear taking, HIV, childhood immunisations and telephone triage.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. They held monthly multi-disciplinary meetings which included a comprehensive mix of staff involved in patient care. For example, Macmillan nurses, community matron, district nurse and practice manger. We saw from minutes that patients receiving or requiring palliative care were discussed demonstrating evidence of assessment of need, recording of resuscitation arrangements and clear action points. We saw a clear statement of aims of patients reviewed on the palliative care register and district nurse and community matron lists. All known existing patients were discussed each month and new patients were discussed and added to the list. Patients who had attended A&E were monitored prior to the meeting. Following discussions with staff it was clear that this system worked well and was seen as a useful forum for sharing important information regarding changes in patient care.

The practice had taken up an enhanced service which involved identifying and care management for patients at risk of admission to hospital or who were seriously ill and care was being delivered in line with best practice. We saw that they had completed a significant number of care plans and this was still work in progress. The practice told us they had experienced difficulty in establishing links with local mental teams but have made contact with local psychiatrists to discuss care when necessary.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically. Each clinician checked discharge letters for their own patients and was responsible for any actions or review or change in medications. Staff we spoke with understood their roles and felt the system in place worked well.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. The practice had an identified clinical governance lead for out of hours services who ensured that good links were maintained. They ensured that information regarding patients who were at risk of admission or requiring the out of hours service were identified and information was faxed to the out of hours service.

Electronic systems were also in place for making referrals and the practice made referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. The practice used SystmOne electronic patient record system to allow all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that there was an option for patients to opt out of allowing their care summary record to be shared and this was clearly shown on the system.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff we spoke with were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented 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 nurse told us that they carried out a learning disability clinic with one of the GPs who had undergone learning disability training. Reception staff and the nurse told us that they would liaise with the GPs if they had any concerns regarding a patients understanding of their care.

Nurses and GPs we spoke with demonstrated a clear understanding of Gillick competence. Gillick competence refers to a child under 16 who is able to demonstrate they have legal capacity to make decisions and give consent to care and treatment without parental consultation. Staff were able to demonstrate the importance of recording both verbal and written consent to procedures. Patients we spoke with told us that both doctors and nurses always sought consent before delivering any treatment or carrying out any procedure.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice offered all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. Following discussions with staff we noted that GPs and the practice nurse used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, GPs ensured that nursing home patients had received their flu vaccinations when carrying out visits to the homes.

The practice also offered NHS Health Checks to all its patients aged 40-75 which were carried out by one member of the reception staff. They demonstrated a clear understanding of when to refer patients on to the GP from these checks. Practice data showed that one third of patients in this age group had taken up the offer of the health check which was an increase from the previous year.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all of these patients were offered an annual physical health check. The practice had a systematic approach for calling for these patients and we saw evidence of this. The practice had seen all moderate and severe patients last year who had care plans and a health action plan which had been adapted and was in picture form to help patients understand their care. The practice hand delivered invitations for health checks and with specimen receptacles to ensure patients had time to understand and bring samples with them to their appointments. We saw that the practice liaised with the local council to identify any learning disability patients who may not have been on the register.

The practice offered cervical screening appointments but had acknowledged that many patients worked and therefore had not been able to attend. The practice set up a specific clinic out of hours to enable women who worked to attend. Patients were notified of this by post to encourage uptake of the service. The practice offered chlamydia screening where appropriate. They did not provide contraceptive services for intra uterine contraceptive devices or contraceptive implants. However, the practice signposted patients to the local NHS trust clinic or another practice who offered these services.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations at the age of 24 months was in line with the CCG and non-attenders were followed up by the practice nurse. A midwife attended the practice once a week and the GP carried out a child health medical at 8 weeks of age when the first immunisation was given. The practice had developed a card that they sent to all patients who had delivered a new baby advising them of the service available to them.

All patients over the age of 75 had been allocated a named GP. The practice had taken up the directed enhanced service for patients who were at high risk of admission to hospital. GPs had identified patients at risk and reviewed

Good

Are services effective?

(for example, treatment is effective)

their care and completed care plans to identify ways of reducing the risk of admission. Patients on the unplanned admission register who had been admitted to hospital were contacted by letter to arrange follow up.

The practice had recently adopted a more systematic approach to structuring reviews for patients with long-term conditions. They were identifying patients with multiple conditions in order that they could be called for a review of all conditions and therefore improve uptake and outcomes.

The practice had acknowledged that their achievement in areas of review of patients suffering with diabetes was below the CCG and national average and had responded to this. One GP had been identified as a lead for this and was undergoing additional training. We spoke with three patients who told us they suffered with long-term conditions who expressed that they received good care and support from the GPs and nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice 83% of patients said that the GP they saw treated them with care and concern. Sixty-nine percent of patients reported satisfaction at seeing their own named GP compared to 50% across the CCG area.

Patients completed CQC comment cards to provide us with feedback on the practice. We received three completed cards two of which were expressed improvement in access to appointments and satisfaction at the change of telephone number and the fact it was easier to get through on the telephone. Patients told us they felt the practice offered an excellent service and staff were efficient, helpful and caring.

We spoke with six patients who told us that staff treated them with dignity and respect. Patients we spoke to were positive regarding the care they received and told us that they felt doctors and the nurse were caring and thorough. All patients we spoke with told us their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The main waiting room was separate from the reception area that provided additional privacy. We saw that there was a sign notifying patients that if they needed to speak in private to the reception staff this could be accommodated.

The practice offered a chaperone for when intimate examinations were being carried out. There was a sign advertising this to patients. Patients we spoke with during our inspection confirmed that they had been offered a chaperone when necessary.

We observed staff dealing with patients and saw that they were respectful and helpful to people on arrival and during their visit to the practice. The reception desk was enclosed and shielded by glass partitions that helped keep patient information private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions and 76% felt the GP was good at explaining treatment and results. Both these results were similar to that of other practices within the CCG.

Patients we spoke to 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. 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 they wished to receive.

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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection told us that they were supported by the GP and nurse when dealing with their condition. We spoke with patients who had suffered bereavement who confirmed that the GP had offered support when they needed it. The practice told us that the named GP may visit if it was deemed necessary following bereavement. There was information in the waiting room signposting patients to a variety of support groups including bereavement.

Good

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. We saw that the practice had a carer's board showing written information available for carers to ensure they understood the various avenues of support available to them.

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 people's needs and were establishing systems to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice had recently undergone changes in personnel as the practice manager had left and the senior partner had retired. Therefore, the practice was in the process of reviewing and establishing how they intended to address people's needs. They had identified diabetes and management of long-term conditions as a priority.

The NHS England Local Area Team (LAT) and the Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw the action points from a recent meeting with them where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, the practice was aware of improvements required in diabetes care and management and agreed to standardise the clinic approach and protect GP time to support the practice nurse.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. For example, patients with learning disabilities who attended for health checks were allocated 45-minute appointments. Home visits were made to local care homes to those patients who needed one.

The practice had ongoing actions from suggestions for improvements to the way it delivered services in response to feedback from the Patient Participation Group (PPG). For example, introduction of SMS text messages to confirm and remind patients of appointments and also information regarding DNAs on the electronic boards at the surgery. They are also introducing the facility to enable prescripts to be sent electronically to nominated pharmacies.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. They had access to translation services and could also access language line if required. Staff we spoke with told us that this was not requested often as patients tended to prefer to use a family member.

The practice had provided equality and diversity training in 2012 and the practice manager told us they intended to repeat this next year. Staff we spoke with confirmed that they had completed the equality and diversity training.

The premises and services had been adapted to meet the needs of people with disabilities. All consulting rooms were on the ground floor and there were double doors allowing wheel chair access. The waiting room was large and enabled easy access to move around when using mobility aids.

Access to the service

The main practice reception opened at 8.45am and appointments were available from 9am to 6pm on weekdays except Wednesdays when it closed at 5pm. The practice offered pre-bookable extended hours appointments on Monday from 6pm until 8pm and Saturday from 8.30am until 10.45am for people who were unable to access the practice during normal hours. The branch practice reception opened at 8.45am and appointments were available Monday to Friday 9am until 6pm except Thursdays when they closed at 5.pm.

Comprehensive information was available to patients about appointments on the practice website and in a practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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-hours service was provided to patients.

Patients were generally satisfied with the appointments system and patients we spoke with told us they found it easier making appointments now the new telephone line had been installed. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice was situated on the ground floor and all services for patients were delivered on this floor. We saw that 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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. We saw that the practice complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example, there was a section in the practice leaflet that explained what to do. The complaints form available to patients also set out the process clearly. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager showed us the complaints files and we looked at six complaints received in the last twelve months and found that four of the six had been acknowledged within 3 days and all had received a full report within 20 working says. We saw that each complaint had been individually files and showed progress with it and any actions taken. There was also a summary log of complaints listing issues and actions taken which the practice made available to us. Complaints were discussed at clinical meeting six monthly. We saw they had been discussed in May 2014 and the next meeting was scheduled for December 2014. Complaint outcome letters were seen and were appropriate and offered remedial actions to address complaints.

We saw that the practice telephone number had been changed from an 0844 number as a result of patient complaints.

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

A few months prior to our inspection the practice had undergone changes in leadership as the senior partner had retired and a new senior partner had taken over leadership of the practice. A new practice manager had also been appointed. Discussions with the new senior partner demonstrated that they had vision of where the practice needed to focus and a commitment to developing the practice to deliver high quality care and promote good outcomes for patients and told us they completed a practice development plan each year.

The practice was clear regarding areas which required development and had already made improvements in areas such as chronic obstructive pulmonary disease. They demonstrated that they had already started taking actions to develop chronic disease management further but acknowledged that this would take time to demonstrate success. Discussions with staff showed that the vision and values were shared by all staff we spoke with. However, there was no strategic plan documented which could be shared with all members of staff to facilitate clear planning to achieve the vision.

Staff told us that since the change in management all of the GPs were becoming more involved and keen make improvements. The new practice manager told us that they had been very well supported by the GPs in their new role. All staff we spoke with demonstrated a commitment to delivering the best care for patients but the practice should develop a clear written strategy and development plan and share with all staff to help improve effectiveness.

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. We looked at a selection of these policies and procedures, for example the induction policy, management of sickness, bullying at work and equality which were appropriate. The practice manager told us that all staff were required to sign each year to confirm they have read the staff handbook containing policies and procedures. We saw that this was signed for 2014 by all staff.

The practice held monthly meetings where governance issues were discussed. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing below the CCG and with national standards in some clinical areas, for example, diabetes, hypertension and mental health. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The senior partner told us that their focus was on these QOF areas and we saw that they had been making plans to address this.

The GPs told us about a local peer review system they took part in with neighbouring GP practices. One of the GPs attended this meeting and fed back to the practice. They had recently looked at the appropriateness of referrals to secondary care.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as environmental and building risks. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented with the exception of staffing risks which the practice should add to the risk register.

Leadership, openness and transparency

We saw that the practice had a leadership/governance structure which was on display for all staff to see. They had identified a lead GP for safeguarding, safety and quality and staffing. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that 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 regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or any other time.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy,

Are services well-led?

Good

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

management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received and through the patient participation group. We looked at results of the patient survey and saw that difficulty getting an appointment was still an issue. We saw as a result of this the practice had introduced a new telephone number to make it easier to get through and that patients with long term conditions were given 'open access' to appointments.

We spoke with a member of the PPG who confirmed that the group had been active for three years. They told us that they worked with the practice to make suggestions for improvement and implement changes in response to patients' comments. The PPG member reported that there was good communication with the GPs as they always attended the meeting. They commented that the practice was good but that they would like more information regarding the practice vision, annual plans and strategy. We saw minutes from practice meetings that were well attended and generally occurred alternate months. These were available on the practice website for patients to access.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a newly appointed a health care assistant. We saw that the practice had sourced a comprehensive training course to develop the staff member in their role. Staff 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 that was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff appraisals had not been carried out during 2014 as the practice manager had only recently been appointed. They told us that they would be carrying out staff appraisals early in 2015 when they had accessed their training to fulfil this task effectively. However, staff told us that if they felt they needed any training or identified any training needs they could discuss with the practice manger or GPs who were always supportive of training. The practice manager confirmed that appraisal training was to take place in February 2015 and appraisal would be completed after that time.

The practice had completed reviews of significant events and other incidents and this was logged. Staff told us that significant events were investigated and discussed at the time of occurrence and were reviewed and shared at meetings six monthly. We saw minutes from the meeting held in May 2014 and the next one was due to take place in December 2014.