Drs Mirza, Sukhani and Partners

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Mirza, Sukhani and Partners on 28 November 2014.

The practice achieved an overall rating of Good. This was based on our rating of all of the five domains. Each of the six population groups we looked at achieved the same good rating.

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity 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.
- 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.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should

- Carry through the practice plan to replace the remaining carpeted areas with vinyl flooring
- Ensure all staff are familiar with fire evacuation procedures
- Ensure multidisciplinary team meetings are arranged to discuss and provide for the needs of the palliative care patient

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to 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 patients safe.

Are services effective?

Good

The practice was rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice about the same as other practices for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us that they were able to get an appointment when they needed one, but there was often a wait to see the GP of their choice. 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 that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership

Summary of findings

structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was not active but the practice had taken action to reconvene an active PPG. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 that outcomes for patients were good for conditions commonly found in 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff assisted GPs with lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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 all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. 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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly liaised with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care 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. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. They were from different backgrounds and with different health needs. The patients we spoke with were very complimentary about the care and treatment they received. They said clinical staff listened and responded to their needs and they were involved in decisions about their care. Patients told us that the practice was always clean and tidy.

We reviewed the 12 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection.

Eleven of the comment cards were very positive. Comments on the cards noted that the staff were always friendly, professional, caring, empathetic and treated them with dignity and respect.

The results from the National Patient Survey showed that 96% had confidence and trust in the last GP they saw or spoke to, and 75% described their overall experience of this surgery as good. These findings were supported on the day of our inspection by the patients we interviewed or gathered comments from.

Areas for improvement

Action the service SHOULD take to improve

- Carry through the practice plan to replace the remaining carpeted areas with vinyl flooring
- Ensure all staff are familiar with fire evacuation procedures
- Ensure multidisciplinary team meetings are arranged to discuss and provide for the needs of the palliative care patient

Drs Mirza, Sukhani and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP acting as specialist adviser.

Background to Drs Mirza, Sukhani and Partners

Drs Mirza, Sukhani and Partners provide a range of primary medical services for people in Hockwell Ring in the Leagrave area of Luton, and serve a registered population of approximately 5487 patients. The practice population consists predominantly of mixed ethnic minority groups with some levels of socio economic disparity, language barriers and different religious and cultural needs.

Clinical staff at this practice include three GP partners, one salaried GP, one practice nurse and one healthcare assistant. Management, administration and reception staff support the practice. Community nurses, health visitors and a midwife from the local NHS trust also provide a service at this practice. A mix of male and female clinical staff is available.

When the surgery is closed out of hours care is accessed through the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out this inspection 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.

This provider had not been inspected before and that was why we included them.

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?

Detailed findings

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. These 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)

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 28 November 2014.

During our visit we spoke with a range of staff including GPs, reception staff, nurses, the registered manager and other practice staff and spoke with patients who used the service. We observed how people were dealt with by staff, talked with carers and/or family members and looked at patient records. We 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 patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff had reported an incident with administration of childhood vaccination. As a result the practice had introduced a system that required clinicians to double check patient's records to make sure it had not been administered before.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the past year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the past year and we were able to review these. Significant events were discussed during practice meeting and we saw evidence that confirmed this. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts including medication alerts were disseminated by the practice manager to the appropriate clinical and administrative practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They were able to confirm the system used at the practice to deal with these alerts and record the actions 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 looked at training records which showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about 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 and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of office hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The lead role included promoting staff awareness of safeguarding and communication with other healthcare professionals who linked with the practice regarding these issues. The practice demonstrated good liaison with partner agencies such as the police and social services.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and people who were housebound.

A chaperone policy was available and staff we spoke with confirmed that chaperoning was usually carried out by clinical staff. Designated non clinical staff also acted as chaperones but we did not see records that showed that they have been trained to act as a chaperone. The practice after our inspection wrote and told us that all staff had now received this training.

Medicines management

There were systems in place for managing medicines safely. We saw that all medicines that were in general use were securely stored in locked cupboards or refrigerators as appropriate and were only accessible to authorised staff.

There was a policy for ensuring medicines stored in refrigerators were kept at the required temperatures. This was followed by the practice staff, and staff described to us the action they would take in the event of a potential failure.

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

Good

Are services safe?

Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance and we saw evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Individual blank prescription sheets were not tracked through the practice and kept securely at all times. We did not see a documented system that assured us that blank forms that were used to issue computerised prescriptions were handled in accordance with national guidance. Following our inspection the practice manager wrote to us and told us that they had introduced a system to track individual and computerised prescription pads so these were logged and kept secure in locked cabinet.

We reviewed the repeat prescriptions system in use at the practice. Repeat prescriptions requests could be made by patients online or by written request at the practice. There was a repeat prescription review process in place, which meant patients that used medicines over longer periods were required to attend for periodic reviews with their GP before they continued taking the medicine to make sure it was still appropriate treatment for them.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. 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 lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff told us that they cleaned examination couches in consultation rooms after each patient use.

We found that the practice was carpeted throughout. The senior partner told us that the practice had a rolling programme to replace the carpets with vinyl flooring which was better suited for clinical environments. The practice manager after our inspection wrote to us and confirmed that the treatment room carpet was scheduled for replacement on 20 May 2015 with vinyl flooring.

The chairs in the waiting room were fabric covered. The practice manager told us that these were cleaned periodically but we did not see evidence that these had been cleaned recently. The senior partner told us that these too will be replaced with chairs with wipe clean surfaces. Following our inspection the practice manager wrote to us and told us that these chairs will be replaced by January 2015.

There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. However this policy was not explicit in whom to contact in the event of an injury. Following our inspection the practice manager wrote to us and told us that they had amended this policy with the relevant contact details.

Privacy screens around examination couches were of the disposable type and we saw evidence that these had been changed recently. Hand washing sinks with hand soap and hand towel dispensers were available in consultation and treatment rooms.

The practice had not tested its water system for legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice manager after our inspection confirmed that a risk assessment by an external contractor was completed on 27 April 2015 and they would act on any recommendations made.

The practice had appropriate arrangements for the disposal of clinical and domestic waste. We saw that both clinical and domestic waste prior to collection by the waste disposal contractor were stored in a room that was also used to store clean items. Following our inspection the practice manager wrote to us and told us that had now moved this storage to an outside secure locked facility.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All

portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the blood pressure monitoring machines.

Staffing and recruitment

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 through the Disclosure and Barring Service (DBS). The practice had recruitment procedures that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements, calculated on their expected need and agreed by the provider at their meetings.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety representative.

Identified risks were included on a risk log. Risks were assessed and any actions needed recorded to reduce and manage the risk. We saw that any risks were discussed at practice and provider meetings.

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 the practice produced a list of patients with long term conditions so their care could be reviewed periodically to ensure optimum treatment. This prevented deterioration of their condition and helped avoid unplanned hospital admission. There were emergency processes in place for identifying acutely ill children and young people. The practice access policy ensured children under the age of 5 years had access to a GP or a nurse on the day.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen. Staff members, knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available at the practice and staff knew their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked 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 rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. The practice manager told us that a fire drill has been scheduled to happen before end of April 2015.

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 approaches to treatment. They were familiar with current best practice guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us they used the internet to access and keep up to date with NICE guidelines. We saw that clinical commissioning group (CCG) guidelines and locally agreed protocols were easily accessible electronically via the practice's computer system. 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. GPs told us new guidelines were discussed and disseminated through practice meetings and we saw evidence of this.

The GPs told us they led in specialist clinical areas such as diabetes and chronic obstructive pulmonary disease (COPD), and the practice nurse and a healthcare assistant supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice monitored their performance in many areas. For example the practice had audited A&E attendance with a view to reducing those that were avoidable. Following the audit the practice had implemented a number of measures to reduce inappropriate attendance. A re-audit in 2014 had shown that there were no improvements in avoidable attendance. The practice had concluded that not enough time had passed since the implementation to produce any viable result and intended to audit again shortly.

We reviewed the data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. We saw evidence of regular review and assessment of patients with chronic conditions and referrals to specialist services as appropriate.

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

Interviews with GPs indicated that the culture in the practice was that patients were referred on need and that age, sex and race were taken into account as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. Information from the quality and outcomes framework (QOF) which is a national performance measurement tool showed the intended outcomes were being achieved for patients. For example the percentage of patients new patients diagnosed with dementia was better than average compared with the diagnosis rate with other local practices and nationally. This ensured appropriate care was planned and delivered in a timely way. The practice was not an outlier for any QOF clinical indicator.

The practice had a system for completing clinical audit cycles. These were quality improvement processes that aimed to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local CCG initiated audits. We saw five recent examples of these at the practice two of which related to medication prescribed to reduce the amount of cholesterol absorbed by the body, and avoidable admissions to the A & E department. Both had been completed.

The GPs told us clinical audits and monitoring were often linked to medicines management information, safety alerts or as a result of information from the QOF. For example, we saw that the practice together with the community pharmacist regularly audited its prescriptions and ensured it complied with current medicine management information.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice had introduced measures to manage patients who had a high cholesterol level compared with other practices nationally.

Good

Are services effective?

(for example, treatment is effective)

The practice had a palliative care register and had regular contact including with the community matron where the care and support needs of patients and their families were discussed. The practice manager told us that formal multidisciplinary meetings were evolving and that these should be functional soon.

Effective staffing

Practice staffing 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.

Staff we spoke with confirmed that appraisals had taken place and included a process for further review of identified learning needs and targets made during appraisals. The manager told us that appraisal records were kept in individual staff files and showed us one example. Our review showed that staff had been trained in core subjects such as safeguarding children and vulnerable adults, health and safety and manual handling and specialised subjects such as asthma and diabetes.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the health care assistant we spoke with was able to demonstrate that they had appropriate training to fulfil their role and had attended dedicated training in areas such as recording blood pressure, performing health check.

The practice manager told us that they were a very supportive practice and had encouraged practice staff in their professional development. For example the practice nurse had been supported to become a nurse prescriber, and the phlebotomist supported to become a trained healthcare assistant.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was when doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. The GPS were either validated or had a scheduled programme for revalidation. The practice nurse was supported to attend updates to training that enabled them to maintain and enhance their professional skills.

The practice had a process to manage poor performance both for clinical and non clinical staff.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically by post or by fax.

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. We saw examples of personalised care plans which contributed to this process including for those patients who had complex needs or suffered from a long term condition. There were clear mechanisms to make referrals in a timely way which ensured patients received effective, co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up with unplanned admissions to a hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the practice had a system to follow up patients that were admitted to hospital and to take measures to prevent reoccurrence.

We did not see evidence of regular multidisciplinary meetings but the GPs told us that they liaised with the district nurse, social worker, palliative care nurse and the community matron as appropriate to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register.

Information sharing

There was effective communication, information sharing and decision making about a patient's care across all of the services involved both internal and external to the

Good

Are services effective?

(for example, treatment is effective)

organisation, in particular when a patient had complex health needs. Care was delivered in a co-ordinated and integrated manner with appropriate sharing of patient sensitive data. For example we saw evidence of information sharing across community based services, hospital services and specialist NHS services to achieve the best health outcomes for two patients with complex needs. There were arrangements to receive hospital summaries of recently discharged patients. These were directed to the relevant GP for their review and any follow up action.

The practice used electronic systems to communicate with other providers. Electronic systems were also in place for making referrals, and the practice made use of the Choose and Book system for making referrals. (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 to provide staff with the information they needed. Staff used an electronic patient record called SystmOne 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.

The practice had a system to communicate with other providers. We saw evidence of information sharing, for example with the out of hours service, palliative care team and the Macmillan service.

The practice supported the electronic NHS summary care record scheme for emergency patients. Under the scheme, with a patient's consent, a summary of their care record is provided to healthcare staff that treat patients in an emergency or out of hour's situation which enabled them to have faster access to essential clinical information about that patient. The practice planned to have this scheme fully operational during 2015.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. There was a GP clinical lead to whom practice staff referred issues related with mental capacity. 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 in conjunction with the clinical lead. GPs and practice nurse we spoke with told us that they referred to Gillick competency when assessing young people's ability to understand or consent to treatment.

The practice administered joint injections (as a minor surgical procedure) which helped to reduce inflammation and pain within a joint, and had a process to obtain consent before this procedure was performed. A GP told us that a record of the relevant risks, benefits and complications of the procedure would also be made in the patient's records at the same time.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Young people aged 15-24 were offered chlamydia screening during the health check. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 30 patients in this age group took up the offer of the health check (out of 89 patients who were offered the health check during the months of August, September and October 2014). Clinical staff used their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers or signposting patients to other appropriate services who helped them develop healthier behaviour and lifestyles. There was a variety of health promotion information for patients to access in the practice and on the website.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and of all patients in need of palliative care and support irrespective of age. The practice had also identified the smoking status of 98% of patients over the age of 16 and actively offered smoking cessation advice to relevant patients.

Good

Are services effective?

(for example, treatment is effective)

The practice offered proactive diabetic care. For example 88% patients with diabetes had received a foot examination and risk classification within the preceding 15 months.

The practice's performance for cervical smear uptake was 78%

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 12 completed cards and all but one were positive about the service experienced. Patients commented that the service received was professional and staff and were efficient, helpful caring and accommodating. Staff had treated them with dignity and respect.

We spoke with four patients on the day of our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. They spoke highly about the practice and the care and treatment they had received. They felt well looked after and staff listened and attentive to their needs. One patient told us about how a GP had followed up the care and treatment of their child the next day by telephone following attendance at the practice the previous day.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. This survey showed that 77% reported that their GP was good at treating them with care and concern which was similar to other practices in the local CCG area and aligned with the views of patients reported on the day of the inspection.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted all treatment and consulting rooms had privacy curtains installed to ensure the patients dignity and privacy was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There was a clearly visible notice in the patient reception area and on the practice website stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and usually had sufficient time during consultations. Staff had listened to their opinion and considered these when agreeing treatment options and medication. Patient feedback on the comment cards we received was also positive and confirmed these views.

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. The national patient survey showed that 80% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were similar to other GP practices in the local CCG area.

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. A number of GPs that worked at the practice also spoke the most common Asian languages which enabled patients to consult with the GPs in their own language

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We observed patients in the reception area being treated with kindness and compassion by staff.

The practice made referrals to emotional support services such as Improving Access to Psychological Therapies (IAPT), and signposted patients to support services such as bereavement counselling and MIND the mental health charity.

Notices in the patient waiting room, the life channel TV in the patient waiting room and the practice website also told people how to access a number of support groups and organisations. The practice computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Patients could access a male or female GP. All patients with long-term conditions and those over the age of 75 years had a named GP who had overall responsibility for their care and support. The practice reviewed patients with long term conditions monthly and they were given a copy of their personalised care plan.

The practice offered longer appointments for patients who might require them, including patients with learning disabilities, mental health conditions, and multiple long-term conditions. Home visits and telephone consultations were available to patients who required them, including housebound patients and older patients.

For children and young people the practice offered appointments outside of school hours on Monday, Tuesday, Thursday and Friday.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback and had made available more appointments at earlier and later times throughout out the week to help meet demand.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff were aware of patients for whom English was not their first language. They said they had a translation service if required but that most patients came with their own translator. A number of GPs that worked at the practice also spoke the most common Asian languages which enabled patients to consult with the GPs in their own language.

The practice had not arranged specific equality and diversity training. However the staff we spoke with demonstrated a good understanding of equality and diversity. Any specific issues were discussed at practice meetings and staff were actively asked for their opinions and views.

There were facilities for patients who used a wheelchair. There was a door bell for patients to ring for help in accessing the surgery at the front door when using a wheelchair or pushchair for access. Consultation rooms and the treatment room were at ground level. A toilet for patients with disabilities including grab rails and alarm was available. The practice had disabled parking available.

Practice staff told us they knew the patient list well and flexible appointments in terms of time and length of appointment times could be accommodated based on their specific needs.

The practice operated a policy to care for patients without stigma or prejudice. Homeless patients for example were able to register the same way as other eligible patients and the practice a flexible approach when providing the needs of the individual.

Access to the service

The practice was open for consultations, Monday 9 until 11.30am, 3.30 until 7.30pm, Tuesday 9.30 until 12 noon, 4 until 6.30pm, Wednesday 9 until 11.30am, Thursday 9 until 12 noon, 3.30 until 6pm and Friday 9.30 until 12 noon, 4 until 6.30pm. The extended appointments on Monday was useful for patients who could not access the practice during working hours.

Patients could book appointments online, over the phone, or in person. When appointments were full or where appropriate, patients were also offered a telephone consultation with a GP, or a practice nurse.

Comprehensive information was available to patients about appointments on the practice website and on the practice information leaflet. Information provided included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, a recorded message gave the telephone number they should ring for the out-of-hours service.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available to housebound patients and to patients who lived in care homes.

Patients were generally satisfied with the appointments system. Information from the national patient survey

Are services responsive to people's needs?

(for example, to feedback?)

showed that 71% of those who responded were able to get an appointment to see or speak to someone. This contrasted with 81% across similar practices locally who were able to get an appointment to see or speak to someone. In response the practice had made available more appointments at earlier and later times throughout out the week to help meet demand. However the patients we spoke with confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

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

Information on how to make a complaint was available in the practice leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Staff told us they would try to diffuse any complaints at the time, and if that did not resolve the issue, direct patients to the practice manager. None of the patients we spoke with had ever needed to make a complaint about the practice.

A complaints log was kept and we reviewed the complaints received in the past year and found that these had been investigated and responded to in a timely manner. Staff told us that complaints received were discussed during practice meetings so they were able to learn and contribute to determining any improvements that may be required. We reviewed the minutes from practice meetings which showed evidence of discussion shared learning. Staff we spoke with were aware of the system in place to deal with complaints.

We looked at the report for the last review which showed a number of complaints related to identified themes. For example to the appointments system and access to appointments. We saw that the practice had taken action to address the issues raised.

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 was dedicated to improving patient care and safety through timely healthcare interventions. The practice team was committed to working in partnership with patients and this was evident within the practice's statement of purpose.

Staff we spoke with shared this vision and showed enthusiasm to provide a wide range of clinical services that benefited their patients and knew their responsibilities in making this vision a reality.

The practice had a two year development plan which included improvements to the premises such as the flooring, seating as well as clinical care improvements such as evaluation of the healthcare assistant's role and consideration to provide dedicated clinics for people with long term conditions.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff through the shared drive on any computer within the practice. We randomly looked at five of these documents and found that these had recent review date.

The practice used the quality and outcomes framework (QOF) to measure its performance. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The QOF data for this practice showed it was performing in line with national standards except cholesterol monitoring for the diabetic patient and holding multidisciplinary meetings for the care of patients on the palliative care register. Discussion with the lead GP indicated that the practice was addressing these issues through targeted prescription of drugs to lower cholesterol levels and by having regular meetings with palliative care nurses and district nurses.

The practice belonged to the Larkside cluster group in which eight local practices worked together to improve services for patients. For example this group was currently working to reduce unplanned admissions to the hospital.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example as a result of clinical audit the practice was able to bring antibiotic prescription levels to that of similar practices in the local CCG area.

The practice had a system for capturing any significant events that had occurred. The information from the significant events was analysed, reviewed and a clear action plan with learning points completed. The practice used this information to minimise the risk by identifying any trends or themes that may have affected patient care and or quality of service.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. Examples of items discussed included compliance with the QOF requirements, applicability and implementation of NICE and medication guidance, and audit results.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there were named leads for safeguarding and infection control. Staff we spoke with were clear about their roles and responsibilities and were clear as to who their line manager was and who to go to for support. They told us they felt valued, well supported and knew who to go to if they had any concerns.

We saw completed minutes from various team meetings that were held on a regular basis, some weekly and others monthly. Staff told us the practice had an open and honest culture and they felt comfortable to raise any issues at team meetings.

Appraisals were carried out annually and staff told us any training needs identified were supported by the practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of procedures, for example recruitment and induction which were in place to support staff. We were shown the electronic employee handbook that was available to all staff, which included sections on equality and personal harassment at work. Staff we spoke with knew where to find the electronic employee handbook if required.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the national patient survey, their website, comments left on NHS Choices website, Healthwatch surveys and the complaints process. We saw that the practice acted on comments received and had improved the number of GP appointments available to book, introduced text reminders for GP appointments and introduced private area within reception for patients to discuss sensitive and confidential issues.

The practice held an open day in October to improve the membership of the patient participation group (PPG). As a result 21 patients had shown an interest to join the PPG. The practice had plans to hold its first meeting on 1 December 2014.

The practice gathered feedback from staff through a variety of methods such as, general meetings, appraisals, one to one supervisory meetings and practice strategy days. Staff told us they were content to give feedback and discuss any concerns or issues with colleagues and management.

Staff told us they were aware of the whistle blowing procedure and would feel comfortable to implement it.

Management lead through learning and improvement

There was a strong focus on learning and training for all staff. Staff told us that the practice supported them to maintain their professional development through training and mentoring. We looked at staff files and saw regular appraisals, which included a personal development plan, took place annually.

Staff also told us that they could request further training to develop their roles. We saw that the practice had supported the practice nurse and the phlebotomist to gain additional training and become a nurse prescriber and a healthcare assistant respectively.

The practice had completed reviews of significant events, other incidents, and complaints, and these had been shared with staff during practice meetings to ensure the practice improved outcomes for patients.