Dr Afzal Hussain

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Afzal Hussain practice on the 27 May 2015. Overall, the practice was rated as Good. Specifically, we found the practice to be good for providing effective, caring, responsive and well led services. It required improvement for providing a safe service for the population groups we assessed.

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

- There were systems in place to address safety risks including analysing significant events and carrying out clinical audits. Staff were trained on how to ensure patients were safeguarded from the risk of harm. The premises were clean and tidy. Improvements need to be made to the way medicines are managed. Staff recruitment procedures ensure suitable staff are employed. Meetings are not regularly held for the purpose of sharing information.
- Patients' care needs are assessed and services reflect the needs of the patients it serves. Staff are provided with training to support them in their role. .
- Patients were positive about the care they receive from the practice. They commented that they are treated with respect and dignity and that staff are friendly, caring and kind.
- The practice has access to online and telephone translation services to support patients whose first language was not English. The GP also spoke several languages. The practice was accessible to patients with mobility problems.
- Most patients indicated they could book an appointment when needed.
- The practice has a system in place for handling complaints and concerns.
- Governance systems are in place to monitor the safety and the quality of the service. The practice has identified the importance of having an open culture and staff are encouraged to report and share information in order to improve the services.

Summary of findings

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

Importantly, the provider must:

- Ensure medicines are managed safely

In addition the provider should:

- Ensure team meetings take place with a record kept of any discussions.
- Ensure staff who act as a chaperone are trained in this area and that the policy reflects the practices carried out.
- Ensure further in house infection control audits are completed.
- Ensure staff daily working practices allow time for the monitoring of medicines and administrative tasks
- Ensure patients know how to make a complaint about the service.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, regular meeting were not held to share this information with staff and talk about lessons learned. Medicines were not managed safely and time was not allocated to the nurse practitioner to complete administrative tasks. Staff had not completed training on how to act as a chaperone and the policy guidance did not reflect the way chaperoning was being provided. The practice was clean and tidy. An infection control audit had been completed in 2013, however, no further in house audits had been completed. There was a recruitment policy and procedure in place to ensure suitably qualified staff were employed. There were enough staff to keep people safe. Staff had been given guidance on how to deal with patients who may presented with challenging behaviour in the form of verbal or physical aggression.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff received training appropriate to their role. Reception staff told us they received regular training including IT systems, safeguarding and basic life support. Multi-disciplinary team and palliative care meetings were held on a regular basis, although a record of these meetings had not been made. Information about the care needs of patients with long term conditions was shared with other health care professionals such as district nurses which ensured the patients' care needs were monitor and they received the care and treatments needed. Patients spoken with confirmed their GP or nurse provided them with information about how to manage their health and stay healthy. For example, patients were given advice on how to give up smoking.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatments. There was plenty of supporting information to help patients understand and access the local services available. We also saw that staff treated patients with kindness and respect. Staff spoken with were aware of the importance of ensuring patients' confidentiality. There was a person centred culture at the practice where the staff

Summary of findings

team worked in partnership with patients and their families. Information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. This included information about mental health support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with Clinical Commissioning Group to secure improvements to services where these were identified. The practice did not have a Patient Participation Group although the practice manager was trying to establish the group in order to obtain patients' views of the service. Most patients told us it was easy to book an appointment when they needed to. Information about how to complain was available.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the values of the practice being patient centred. Governance systems were in place to monitor, review and drive improvement within the practice. There were formal clinical meetings although governance meetings and full team meetings to share best practice or lessons learnt had not regularly taken place. The practice proactively sought feedback from patients. Staff had received induction training and attended training and events appropriate to their roles. The practice had a protocol for whistleblowing and staff spoken with were aware of what to do if they had to raise any concerns. Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered advice on health promotion to prevent ill health and to ensure that patients enjoy a healthy lifestyle. The practice monitored patients over the age of 65-years and offered a variety of health checks such as breast screening, bowel screening, abdominal aortic aneurysm screening and general health checks including blood pressure, diabetes and cardiovascular risk assessment. Flu, pneumonia & shingles vaccinations were available along with osteoporosis risk assessments. Memory screening assessments were carried out and care plans including risk assessments were available to patients over 75 years. Home visits were available to housebound patients to routinely monitor chronic disease or in more urgent circumstances to assess acute illness. A service was provided to patients in a number of nursing and residential care homes. These patients have a care plan in place which is reviewed every 3 months.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice aimed to provide the patient with continuity of care with a named GP. The GP worked with outside services to ensure patients received the care they needed within the community. These services included the district nurses, the community matron and the crisis team who were able to access intermediate care. Patients and their carers were provided with information to help them manage their condition in the best possible way. Patients were provided with a reserve of medicines for when their conditions worsened at home. Care plans were in place which allowed the GP to share information with other health services involved in the patients' care. Patients were assessed for their on-going emotional, social and psychological conditions to improve their quality of life. Treatments were provided where depression was identified. A review of patients' medicines was completed regularly to ensure the on-going necessity of medication and to monitor safety.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The GP worked closely with other healthcare providers such as health visitors, midwives, community paediatric nurses and child safeguarding services to ensure information about patients was shared appropriately. The GP provided support and

information for children's health through GP and practice nurse consultations for both acute and chronic disease. A routine cardiovascular risk assessment screening was provided for men's health. The GP or the practice nurse offered contraceptive advice, cervical screening and breast assessments. Pre pregnancy counselling was available along with antenatal care from the community midwives and GP. Chlamydia screening was available to 16-25 year olds and the HPV vaccination was offered to teenagers Childhood vaccinations and flu and pneumonia vaccinations for at risk groups and some travel vaccinations were available. Clinical staff identified children and young people who may be at risk or suffering from abuse or neglect. Missed appointments and admissions to A & E were monitored. Concerns raised in relation to behaviour such as school difficulties, behavioural problems, sleep disturbances, sexualized behaviour were respond to promptly. Full annual health checks were offered to patients with a learning disability to identify early medical conditions and improve their overall health. Referrals to secondary care made as needed. Longer appointments were provided to ensure patients had opportunity to communicate with the clinical staff and to reduce anxiety.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age patients (including those recently retired and students). The practice aimed to ensure that all patients were seen within 48 hours. The practice offered an open surgery system every morning as well as pre-bookable appointments for morning and afternoon surgeries. Late evening appointments were available from 6.30 to 8pm on Fridays. Appointments and prescription could be made or ordered by phone and telephone consultations were available Monday to Friday. Patients were invited for regular health screening to promote a healthy well balanced lifestyle. Holiday vaccinations were available. Cardio-vascular health checks were available for high risk patients over age-40 along with pre diabetes checks. Smoking cessation services were available.

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 recognised its duty to safeguard patients whose circumstances may make them vulnerable and to provide additional measures to support patients who were less likely to seek out medical assistance. The practice operated on the principle of equal opportunities for all patients. Clinics were available at the start of the day as well as the end of the day to encourage these groups of patients to present themselves to the surgery without the need of making prior appointments.

Summary of findings

Safeguarding posters including posters on sexual health were displayed in the main waiting area asking patients / carers to raise any concerns if required. Recent alterations to the practice have now provided disable access to the surgery with an automatic door and ramp for patients who use a wheel chair. Interpretation services were available to patients whose first language was not English. All patients with a learning disability had completed a health check and a link had been established with a local residential unit for refugees placed in the area. The GP had established links with the local travellers' community to support them with their health care needs and a flu clinic was set up at the local mosque to offer a service to patients who were unable to get to the practice due to health problems.

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). Patients could access direct help from a healthcare professional by contacting The Healthy Minds Team. The practice offered either a same day or next day appointments for patients with severe mental health issues in order for the GP to conduct an assessment. Double appointments were given for more complex problems and a system was in place to monitor patients who do not attend follow-up appointments to manage the risk of harm. Staff contact patients with poor memory to remind them of their appointments and regular reviews were booked with the GP to promote continuity of care. Assessments were completed with at risk groups along with memory assessments used for early identification of dementia. Referrals to a memory clinic service were made as appropriate. A mental health care plan was completed with patients with severe mental health problems. Patients and their carers were involved in the development of treatment plans to promote communication with the patient and carer. The practice aimed to provide a comprehensive, holistic approach to promote improvements in patients' mental health and also monitor their physical health and social circumstances. Patients with problems relating to substance misuse were referred to a community drug worker for support

Summary of findings

What people who use the service say

We looked at 25 CQC comment cards that patients had completed prior to the inspection and spoke with 12 patients. Patients spoken with were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were friendly, helpful and overall excellent. Patients told us they had enough time to discuss their healthcare issues fully with the GP. They said treatments were explained, they felt listened to and they felt involved in decisions about their care.

The comments on the cards provided by CQC were also very complimentary about the staff and the service provided. Some patients described the service as excellent. They said the staff were friendly, caring and very supportive. Patients commented that they were always treated with respect. They said the GP listened to what they had to say and they took an active part in deciding about treatments and medicines. Overall patients reported they were very happy with the standard of care and treatment they received.

The GP Patient Survey which collected data from January-March 2014 and July-September 2014 and was published on 8 January 2015 found that:

70% describe their overall experience of this surgery as good. The national average is 67.9%.

64.3% say the GP they saw or spoke to was good at giving them enough time. The national average is 87.3%.

76.2% say the GP they saw or spoke to was good at involving them in decisions about their care. The national average is 74.6%.

77.7% say the nurse they saw or spoke to was good at explaining tests and treatments. The national average is 76.7%.

72.3% found it easy to get through to this surgery by phone. The national average is 71.8%.

We looked at the last patient survey carried out by the practice in October 2014. This indicated that patients felt reception staff greeted them well when they first arrived at the practice. They felt listened to by staff with explanations of treatments being given. Patients indicated they were reassured by staff who demonstrated respect and consideration towards them. Patients knew how to raise concerns. Most patients would recommend the practice. The quality assurance report reflected that the outcomes were satisfactory, if not better when compared to other GP practices.

Areas for improvement

Action the service MUST take to improve

- Ensure medicines are managed safely

Action the service SHOULD take to improve

- Ensure team meetings take place with a record kept of any discussions.
- Ensure staff who act as a chaperone are trained in this area and that the policy reflects the practices carried out.
- Ensure further in house infection control audits are completed.
- Ensure staff daily working practices allow time for the monitoring of medicines and administrative tasks.
- Ensure patients know how to make a complaint about the service.

Dr Afzal Hussain

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, a specialist advisor practice nurse and an expert by experience. Experts by experience are people who have experience of using or caring for someone who use health and/or social care services.

Background to Dr Afzal Hussain

Dr Afzal Hussain practice is based in Bury in Greater Manchester and is a single handed GP practice. The practice treats patients of all ages and provides a range of medical services. The practice is a family run practice that has been established for many years. There were approximately 2847 patients on the practice list with 65% being of south Asian origin. The staff team includes one GP, one nurse practitioner, a practice manager, a business manager and administrative and reception staff.

The practice opening hours:

Monday, Tuesday, Thursday from 08.30 to 18.30

Wednesdays from 08.30 to 13.00

Friday from 08.30 to 20.00

Patients can book appointments in person or by telephone. The practice provides telephone consultations, pre bookable consultations, same day (advanced access) appointments and home visits to patients who are housebound or too ill to attend the practice. When the practice is closed patients access BARDOC for out of hour's services.

The practice is part of Bury Clinical Commissioning Group. The practice has a General Medical Services contract.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services 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, we always ask the following five questions of every service and provider:

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

Detailed findings

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
- Mothers, babies, 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 (including people with dementia)

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on the 27 May 2015.

We reviewed the operation of the practice, both clinical and non-clinical. We observed how staff handled patient information, spoke to patients face to face and talked to those patients telephoning the practice. We discussed how the GP made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We sought views from patients, looked at survey results and reviewed comment cards left for us on the day of our inspection. We spoke with the practice manager, the GP, nurse practitioner, administrative staff and reception staff on duty.

Requires improvement

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations (for example NHS England and Bury and Glossop Clinical Commissioning Group to share what they knew). No concerns were raised about the safe track record of the practice

The practice used information to identify risks and improve quality in relation to patient safety such as incidents and national patient safety alerts. They also routinely recorded and reported critical incidents and significant events and we saw evidence of these. Staff we spoke to were aware of their responsibilities to raise concerns and how to report incidents. We saw examples of incidents reported by the GP who described the event, action taken at the time, discussions following the event and actions taken to prevent re-occurrence. When an incident occurred, generally, information was shared with staff during team meetings to ensure staff were up to date with any changes to practice that may have occurred as a result of the incident. However, meetings had not routinely taken place therefore information was not always shared with staff for the purpose of keeping them updated on these issues. The practice manager told us the practice had gone through significant building work in the last nine months which had resulted in meetings not taking place. They felt the practice was now stable as the building work had been completed and minuted meetings would begin to take place.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence to demonstrate that incidents were investigated and learned from. For example, the process for sharing information with secondary care providers was changed to speed up this process. Also, it was identified that a patient had been given the wrong medicine on one occasion and that an alert had not been recorded on the patients' notes to indicate the possible adverse reaction to this medicine. This incident was reviewed and highlighted the need for improved communication and for staff to be more alert to information recorded on patients' notes.

Reliable safety systems and processes including safeguarding

The practice offered patients a chaperone prior to any examination or procedure. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff spoken with said they had received in house training about the role of a chaperone and described their role in relation to it being a formal or informal chaperone. There was some confusion around the difference between these two roles. There was a chaperoning policy in place but it did not make reference to the different roles.

The patients spoken with told us that while they were offered a chaperone, they had not used this service. Some patients told us they were aware the service existed as they had seen a notice in the patient waiting area.

Staff had access to safeguarding policies and procedures for both children and vulnerable adults. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were available to staff on their computers. Staff had access to guidance flow charts and contact details for both child protection and adult safeguarding teams.

Staff we spoke with confirmed they had received training in safeguarding at a level appropriate to their role and they demonstrated their understanding of the different types of abuse that can take place.

The GP was responsible for managing safeguarding issues. They had completed the appropriate training to support them in this role. Staff spoken with were aware of the safeguarding lead and who to speak to in the practice if they had a safeguarding concern.

Medicines management

Temperature sensitive medicines were stored in a fridge in the nurse clinical room. The fridge was not locked when the room was left unattended. No formal checks were made of the medicines, for example expiry dates, and no stock rotation took place. No records were in place to indicate any monitoring of the medicines had taken place.

Prescription pads were left in the computer drawer overnight rather than in a lockable cupboard.

Medicines to be used in case of an emergency were kept in the GP consulting room. A regular check of these medicines was made with a record of the check in place. A doctor's bag was kept although no medicines held.

Requires improvement

Are services safe?

The fridge was not hard wired into the electricity mains but it would be difficult for it to be disconnected accidentally. The temperature of the fridge was checked and recorded but not the minimum and maximum temperatures. The fridge's electrical safety was tested. We were informed the fridge was not calibrated each month to check it was in good order.

Guidelines were in place about the safe use of vaccines and staff were trained to administer vaccines in order to minimise the risk of harm.

The practice must improve the way they manage medicines.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. They commented the standard of cleanliness had improved since the renovation work took place.

On the day of the inspection the practice was clean and tidy. The practice was cleaned daily by domestic staff employed by the practice. We were informed there was no formal cleaning schedule in place, however this was being addressed. Disposable curtains were in place in both clinicians rooms. Equipment such as disposable gloves and aprons were available. This was to protect staff from exposure to potential infections whilst examining or providing treatment for patients. Hand washing facilities and instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms.

Sharps boxes were available for the disposal of needles and were appropriately located and labelled. The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids.

Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal.

An infection control audit had been completed in 2013. Further in house audits had not been completed.

There was a current infection control policy with supporting processes and guidance which staff were able to easily access. We were informed that the GP took responsibility for managing infection control in the practice. Clinical staff were trained in infection control.

Equipment

There were service contracts in place for regular checks of fire extinguishers and the calibration of medical equipment such as blood pressure monitors, baby scales and ear syringes. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested

Staffing and recruitment

Staff told us there were enough staff to meet the needs of patients. The practice manager explained the staff recruitment procedure which was in line with good practice. A policy was also in place that set out the standards it followed when recruiting clinical and non-clinical staff. All permanent staff working at the practice had received a Disclosure and Barring Service check to ensure they were suitable to carry out their role. 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.

Staff vacancies such as holidays and sickness were covered by the existing staff team which ensured continuity of service provision.

Staff recruitments records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references and qualifications.

Monitoring safety and responding to risk

Staff were trained to respond to risks and ensure a safe environment was provided. We saw evidence that clinical staff received regular cardiopulmonary resuscitation training. The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included systems to control the spread of infection, fire safety and dealing with emergencies. The practice used electronic record systems that were password protected. Health and safety information was displayed for staff.

Arrangements to deal with emergencies and major incidents

Potential risks to the service are planned for in advance. For example a business continuity plan was in place. This

Requires improvement

Are services safe?

identified management plans for dealing with potential foreseeable emergencies and disruptions to the practice. This ensured systems were in place to monitor the safety and effectiveness of the service in the event of an incident to reduce the risk of patients coming to harm. Staff told us they had access to the information and contact numbers to divert the practice phones to individual staff mobiles if needed. Clear lines of communication were identified. The contact details of staff and utility providers were available to support staff in managing an emergency.

Staff had been given guidance on how to deal with patients who may present with challenging behaviour in the form of verbal or physical aggression. Emergency medicines were available to staff. The IT system could alert the GP and nurse practitioner in the event of an emergency.

Fire safety checks were completed regularly to ensure the premises were safe for use. There was a first aid kit and accident book available to record details of any accidents that occurred.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice, the nurse practitioner carried out a health check which included assessing information about the patient's individual lifestyle as well as any medical conditions.

The practice carried out assessments and treatments in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The GP used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital and the referrals were monitored to ensure an appointment was provided within two weeks.

The services provided reflect the needs of the population served.For example, longer appointments were available for patients with long-term conditions or who had carers. The GP had identified a large traveller community near to the practice. They visited the community to offer assessments of patients' care needs and provided opportunistic care.The GP assessed the uptake of child vaccinations and provided parents with information on how to access this service.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF) system. This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed 'similar to expected' in maintaining a register for patients with a learning disability, a register of all patients in need of palliative care/support and having regular multidisciplinary reviews of patients on the palliative care register.

There was no formal recall system for patients with long term conditions; rather this is done opportunistically and through the practice manager contacting patients by phone. This is deemed best way to manage this area of care for patients who did not respond to letters for follow up appointments or who were not proactive in dealing with their own health care issues.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered topics as fire safety, health and safety and information governance. No new staff had been recruited for a number of years although the practice manager informed us they were considering recruiting more reception staff as the practice developed its services.

Reception staff told us they received regular training including IT systems, safeguarding and basic life support. They said the GP encouraged staff to attend training so they kept up to date with new ways of working.

The nurse practitioner told us they planned to have protected learning time one afternoon each week, at present they attended training in their own time. They had completed update specialist training in cytology and diabetes to ensure they were skilled to deliver effective care and treatments. The nurse practitioner told us they felt supported by the GP to carry out their work and would consult with them for advice around clinical issues. They said they did not have time to complete administrative tasks and this impacted on systems such as the monitoring of medicines. The nurse practitioner told us they did not have access to regular supervision and external support. An appraisal of their work took place last year but their development needs were not identified.

Working with colleagues and other services

The practice worked with other agencies and professionals to support continuity of care for patients.

Multi-disciplinary team and palliative care meetings were held on a regular basis. The GP met with health, district nurses, community matrons and Macmillan nurses to discuss any concerns about patient welfare and identify where further support may be required. The nurse practitioner was not involved in these meetings and a record of these meeting was not kept.

The GP worked with 'out of hours' providers to share information to support, for example patients who needed end of life care.

Blood results, investigations and information from out of hour's providers were generally received electronically and disseminated to the GP. Where necessary a procedure for scanning documents such as discharge letters was in place. The GP seeing these documents and results was

responsible for the action required. The GP recorded their actions around results and discharge on the computer system, such as ringing a patient to discuss an abnormal blood result, or arranged to see the patient as clinically necessary.

Information sharing

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

The practice had systems in place to communicate with other providers. For example, there was a system for communicating with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic and paper systems were in place for making referrals to other health care services.

Patients spoken with confirmed they received any test result promptly and often within a matter of a few days.

Information about the care needs of patients with long term conditions was shared with other health care professionals such as district nurses during meetings and daily communication. This ensured the patients' care needs were monitor and they received the care and treatments needed in order to receive the best possible outcomes.

Consent to care and treatment

Consent for childhood immunisation was recorded in patients' notes, but no forms were completed. If a patient was unable to consent to treatments, a review of their care needs would be made in consultation with the GP to establish whether the practice procedures were within their best interest. This is in line with the Mental Capacity Act 2005.

Patients spoken with during the inspection confirmed they were asked for their consent before treatments were given, and they were aware they could change their mind to decisions agreed to

Health promotion and prevention

Patients spoken with confirmed the GP or nurse provided them with information about how to manage their health. For example, patients were given advice on how to give up smoking, healthy eating and advice around individual health issues.

The practice monitored how it performed in relation to health promotion. It used the information from Quality and Outcomes Framework (QOF) and other sources to identify where improvements where needed and to take action. QOF information showed the practice was meeting its targets regarding health promotion and ill health prevention initiatives. For example, in providing diabetes checks, flu vaccinations to high risk patients and providing other preventative health checks/screening of patients with physical and/or mental health conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The patients we spoke with on the day of the inspection told us they were always treated with dignity and respect. They considered the staff were friendly, caring and kind.

We looked at 25 CQC comment cards that patients had completed prior to the inspection and spoke with 12 patients. Patients were very positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were friendly, caring and kind. Patients we spoke with told us they had enough time to discuss their health care issues fully with the GP, treatments were explained and that they felt listened to.

The National GP Patient Survey in March 2014 found that 70% of respondents described their overall experience of this surgery as good. The national average is 67.9%. 64.3% of respondents said the GP they saw or spoke to was good at giving them enough time. The national average is 87.3%. 78.3% of respondents said the GP they saw or spoke to was good at treating them with care and concern. The national average is 82.7%. 63.1% of respondents said the nurse they saw or spoke to was good at treating them with care and concern. The national average is 78.0%.

We looked at the last patient survey carried out by the practice in October 2014. This indicated that patients felt reception staff greeted them well when they first arrived at the practice. They felt listened to by staff with explanations of treatments being given. Patients indicated they were reassured by staff who demonstrated respect and consideration towards them. Patients knew how to raise concerns. The quality assurance report reflected that the outcomes were satisfactory, if not better when compared to other GP practices.

Staff spoken with were aware of the importance of ensuring patients confidentiality. A policy was in place for this purpose which staff could access at any time.

We observed that consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in the GP consulting room and the treatment room so that patients' privacy and dignity were maintained during examinations, investigations and treatments.

Care planning and involvement in decisions about care and treatment

The national GP Patient Survey which collected data from January-March 2014 and July-September 2014 and was published on 8 January 2015 found that 76.2% of respondents said the GP they saw or spoke to was good at involving them in decisions about their care. The national average is 74.6%. And, 77.7% said the nurse they saw or spoke to was good at explaining tests and treatments. The national average is 76.7%.

We spoke with 12 patients during the inspection. Patients commented that they thought the practice would benefit from a female doctor and a midwife to cater for pregnancy related issues and to carry out more personal examinations; these examinations were current being carried out by the nurse practitioner. The GP informed us that arrangements had already been made to recruit a female GP as part of the future development of the service.

Patient/carer support to cope emotionally with care and treatment

There was a person centred culture at the practice where the staff team worked in partnership with patients and their families. Patients told us they were happy with the care and support they received from the GP and nurse practitioner. For example they described the staff as very approachable, kind and caring when they used the service.

Patients who experienced mental health problems were referred to a counselling service or support agency for emotional support.

Information about the support available to patients to help them to cope emotionally with care and treatment was on display in the waiting area. This included information about mental health support.

Patients with long term conditions, and their carers were provided with information to help them manage their condition in the best possible way. Patients care needs were assessed for their on-going emotional, social and psychological conditions to improve their quality of life. Treatments were provided if depression was identified.

The practice aimed to provide a comprehensive, holistic approach to promote improvements in patients' mental

Good

Are services caring?

health and also monitor their physical health and social circumstances. Patients with problems relating to substance misuse were referred to a community drug worker for support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. These included infection control and complaints. The practice used an electronic record system that was password protected. Health and safety information was displayed for staff.

The practice looked to respond to patients' needs through the findings from in house patient surveys, complaints and through the friends and family feedback. Patients spoken with told us they are satisfied with the arrangements in place for repeat prescriptions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and services were delivered in a way that took account of patients' different needs. The GP had engaged with patients who were in vulnerable circumstances and had taken actions to remove barriers for patients who found it hard to access or use services. For example, the practice had access to online and telephone translation services to support patients whose first language was not English. The GP also spoke several languages. There was ramped access at the front of the building and a door that opened automatically at the back of the building.to support patients with mobility problems or who used a wheelchair.

Same day or next day appointments were available to patients with severe mental health issues in order for the GP to conduct an assessment. Double appointments were available to patients with more complex mental health problems or patients with a learning disability to ensure they had time to communicate their health care needs. Patients with problems relating to substance misuse were referred to a community drug worker for support. The majority of patients at the practice are of south Asian origin. In light of this the GP had identified that the best way of making contact with these patients over the winter time is to visit the local mosques and day centres to provide vaccinations. Two Open Clinics were run in the local mosque to provide flu /shingles vaccination. The GP had links with the local traveller community. A 'One Stop Shop' service was provided to these patients by way of providing health advice and limited travel vaccination (Typhoid, Hepatitis) without charge. Open clinics were available to them and courtesy home visits for health checks, chronic disease reviews, blood tests, flu vaccination and children immunisation as required.

The corridor leading to the reception area was narrow and no hand rails were provided. A passenger lift was not provided and the stairs to the first floor were narrow and steep. The practice had recently undergone extensive building work and plans were in place to develop the service. For example, to provide minor surgery. These plans included providing baby changing facilities in the disabled toilet and applying to the local council to provide disabled parking spaces

Access to the service

The practice was open Monday to Friday from 08.30 to 18.30 and from 08:30 to 19:45 on Mondays. Patients could book appointments in person or by the telephone. The practice provided telephone consultations, pre bookable consultations, same day (advanced access) appointments and home visits to patients who were housebound or too ill to attend the practice. The practice closed every Wednesday afternoon. When the practice was closed patients access BARDOC for out of hour's services.

Patient demand was monitored through the appointment system and staff and patient feedback.

The national GP Patient Survey which collected data from January-March 2014 and July-September 2014 and was published on 8 January 2015 found that 72.3% found it easy to get through to this surgery by phone. The national average is 71.8%. And 79.4% describe their experience of making an appointment as good. The national average is 73.8%.

We looked at 25 CQC comment cards that patients had completed prior to the inspection. All comments indicated patients were very happy with the standard of care provided. Patients commented they were able to book an appointment when they needed one, including urgent appointments.

We spoke with 12 patients during the inspection. They all said they were able to book an appointment when one was needed including urgent appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. The practice manager was the designated responsible person who handled all complaints in the practice, although complaints of a clinical nature were handled by the GP. The complaints policy outlined a time framework for when the complaint would be acknowledged and responded to. The complaint policy was also on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Complaints can be sent to the practice by email, in writing or were taken in person or over the phone. The practice manager told us that, when possible, complaints were dealt with at the earliest opportunity so that a patient's needs were dealt with promptly. Staff spoken with said they knew to report all complaints to a senior member of staff.

Two of the 12 patients we spoke with on the day of the inspection knew how to make a complaint about the standard of the service they received. Three patients said they would speak with a member of the reception staff and the remaining 7 patients did not know how to make a complaint.

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 vision was to deliver high quality care and promote good outcomes for patients. The practice Statement of Purpose recorded the practice aims and objectives of which one was to provide care with respect and dignity. The comments on the cards provided by CQC were very complimentary about the staff and the service provided. Some patients described the service as excellent. They said the staff were friendly, caring and supportive. Patients commented that they were always treated with respect.

The staff spoken with were encouraged to do the best for the patient. Quality and care were central to the GP's beliefs. The GP had thought about succession planning and the vision and strategy for the future was to employ a female GP to support female patients with personal examinations which were currently being undertaken by the practice nurse. However a position had not yet been formally advertised.

The practice had identified areas for the future planning of the business. This included monitoring unplanned admissions to hospital and A & E attendances. Providing further training for the practice manager, keeping a record of all meetings held at the practice and engaging with patients with challenging behaviours. Advice was also being taken about how to support staff professional development.

Governance arrangements

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing about average in comparison to other practices in the Clinical Commissioning Group.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically or in a paper format.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment provided. A discussion with the GP showed improvements had been made to the operation of the service and to patient care as a result of the audits completed.

The practice had systems in place for identifying, recording and managing risks. We looked at a number of significant incident reports and actions taken as a result of these reports. Staff were able to describe how changes had been made to the practice as a result of reviewing significant events.

Leadership, openness and transparency

The practice had a protocol for whistleblowing and staff spoken with were aware of what to do if they had to raise any concerns. The practice had identified the importance of having an open culture and staff were encouraged to report and share information in order to improve the services provided. Staff spoken with thought the culture within the practice was open and honest.

Staff were clear about the lines of management and areas of lead responsibility. The GP understood the challenges to good quality care and could identify the actions needed to address them. The practice was a single handed GP service, therefore the GP took responsibility for all areas of clinical care. We discussed with the GP the difficulties of managing a single handed service and the benefits of sharing responsibilities with other staff members. Staff knew to report any issues to the GP or the practice manager. Staff considered they were approachable and there was an open, honest and friendly culture within the team who worked well together. As the practice was small we also established that in the event of concern or worry about the GP or the practice manager, staff would speak to another colleague and escalate the matter from there.

The practice had not held regular team meeting, the most recent being February 2015. The practice manager explained that building work carried out over the last nine months had meant these meetings were difficult to organise and carry out. However, the GP emailed staff each month to inform them that they were available to discuss any issues or concerns

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

Are services well-led?

Good

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

A Patient Participation Group (PPG) did not exist at the practice. A PPG is a group of patients who work with the GP and practice staff to review the services provided and help find ways of improving these services to promote health and improve quality of care. The practice manager was in the process of trying to establish this group in order to gain feedback from patients about the services provided, however, they told us they were finding it difficult to recruit new members.

Staff told us they felt able to give their views and could raise concerns and felt they were listened to.

The friends and family test was carried out by the practice in order to obtain patients' views of the service. This survey asks patients how likely they were to recommend the surgery/services to friends and family. Patients were very positive about the service. They commented that staff were polite and caring and that the GP took time to listen to their concerns.

Management lead through learning and improvement

Clinical and non-clinical staff told us they worked well as a team and had good access to support from each other.

Reception staff told us they were supported with their learning and development needs and that they felt well supported in their roles. Staff were offered annual appraisals to review performance and identify development needs for the forthcoming year.

We were told that regular developmental and governance meetings took place to share information, look at what was working well and where any improvements needed to be made. However, we did not see the most recent minutes of these meetings and the nurse practitioner did not attend these meetings.

There was evidence that the GP had learnt from incidents through auditing significant events and clinical audits.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **ensuring the proper and safe management of medicines.**