Dr Emad Gabrawi

Quality Report

Crookes Valley Medical Centre
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Emad Gabrawi's practice on 12 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all the population groups. It required improvement for providing safe services.

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

- 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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Risks to patients were not always assessed and well managed. The practice had not completed an infection prevention control audit or fire assessment within the last 12 months.
- 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.
- Patients' said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice actively sought feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider must:

- Ensure an infection control audit is completed and action plan implemented in accordance with the findings.
- Ensure a fire assessment of the premises is completed and action plan implemented in accordance with the findings.

In addition the provider should:

- Risk assess and review the absence of oxygen and a defibrillator on the premises to ensure the safety and welfare of patients.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Review the provision of curtains in the GP consulting room.

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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learned were communicated to support improvement. However, some risks to patients who used services were not assessed. The systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. An infection control audit had not been performed in the last 12 months. A fire risk assessment of the premises had not been completed in the last 12 months.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles. Further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice as comparable to those in the local area. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw 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. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and there was continuity of care, with urgent

Summary of findings

appointments available the same day. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

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 their role and responsibilities in relation to this. Staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and held monthly practice meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 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 people with long term conditions. Nursing staff had 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 structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the 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 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. The practice offered a drop in clinic for children aged five and under once a week.

Working age people (including those recently retired and students)

Good

The practice is rated as good for working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. This group of patients were also offered longer appointments.

The practice regularly worked with multidisciplinary teams in the case management of adults whose circumstances may make them vulnerable These patients' had been told 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 people experiencing poor mental health (including people with dementia). Of people experiencing poor mental health, 87% had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of this patient group, 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. It had a system in place to follow up patients who had attended accident and emergency (A&E) whilst they may have been experiencing poor mental health. Staff had attended information sessions on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 10 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We also spoke with seven patients on the day of our inspection. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They also told us they found the practice clean and tidy.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 (18% response rate). The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. The practice was well above the CCG average for its satisfaction scores on consultations with nurses with 85% of practice respondents saying the nurse was good at listening to them and 85% saying the nurse gave them enough time. The GP scores were slightly lower than the CCG average with 73% of practice respondents saying the GP was good at listening to them and 73% saying the GP gave them enough time.

Reception scores were above average as 98% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Areas for improvement

Action the service MUST take to improve

- Ensure an infection control audit is completed and an action plan implemented in accordance with the findings.
- Ensure a fire assessment of the premises is completed and an action plan implemented in accordance with the findings.

Action the service SHOULD take to improve

- Risk assess and review the absence of oxygen and a defibrillator on the premises to ensure the safety and welfare of patients.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Review the provision of curtains in the GP consulting room.

Dr Emad Gabrawi

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor, and a practice manager specialist advisor.

Background to Dr Emad Gabrawi

Dr Emad Gabrawi's practice, or Crookes Valley Medical Centre as it is known locally, is situated in the Crookesmoor area of Sheffield. The practice is part of Sheffield Clinical Commissioning Group (CCG) and responsible for providing services for approximately 2,360 patients under the general medical services (GMS) contract with NHS England. The practice catchment area is classed as within the group of the third most deprived areas in England. The age profile of the practice population differs to other GP practices in the Sheffield CCG area. It has a larger number of male patients aged between 25 years to 44 years old and females 24 years to 34 years old registered at the practice.

The practice has one full time male GP and a female locum GP who covers for the full time GP when he is on leave. They are supported by one practice nurse prescriber, five receptionists, one secretary, one cleaner and a practice manager.

The practice is open from 9am to 6.30pm Monday to Friday. Extended opening was available on Monday evenings until 8pm. There were also arrangements to ensure patients received urgent medical assistance from 6.30pm until 9am. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the practice leaflet and on the website.

Dr Emad Gabrawi is registered to provide; Surgical procedures; Maternity and midwifery services; Family planning; Diagnostic and screening procedures; Treatment of disease, disorder or injury from Crookes Valley Medical Centre, 1 Barber Road, Sheffield, S10 1EA.

Why we carried out this inspection

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

Please note 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

Before visiting, we reviewed information we hold about the practice and asked Sheffield CCG and NHS England to share what they knew. We carried out an announced visit on 12 May 2015. During our visits we spoke with the GP, the practice manager, practice nurse and two members of the

Detailed findings

administrative team. We also spoke with seven patients who used the service and reviewed 10 comment cards where patients shared their views and experiences of the service.

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

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

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

- Older people
- People with long term conditions
- 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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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, we were told staff at the practice had reviewed the process for issuing prescriptions for pharmacies to collect, following an incident where a prescription had been reported lost.

We reviewed safety records, incident reports and minutes of meetings held during the past three years. We saw that the practice had held discussions and 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. We were shown the incident book. We noted the event details were only reported in the book and there was no analysis of the event documented. The practice manager told us events would also be recorded on an incident form which would document the analysis and actions taken. Staff told us they would document incidents in the incident book and inform the practice manager who would complete the incident form.

We reviewed records of significant events forms which had occurred during the last three years and saw this system was followed appropriately. We saw evidence of action taken as a result and the learning had been shared, for example re-visiting the process of pharmacies collecting prescriptions. Where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

'Significant events' was a standing item on the practice meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists 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 were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts which were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any alerts that required action to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and adults whose circumstances may make them vulnerable. We looked at training records which showed all 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 documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The full time GP was the lead in safeguarding children and adults whose circumstances may make them vulnerable. They had been trained to level three in both child and adult safeguarding. They could demonstrate they had the necessary competency and training to enable them to fulfil these roles. 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.

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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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). All nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if the nurse was not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We were told all staff undertaking chaperone duties had a recent Disclosure and Barring Service (DBS) check submitted. The practice manager told us they were waiting for the response. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults whose circumstances may make them vulnerable.

Staff at the practice told us how they identified and followed up children, young people and families living in disadvantaged circumstances. This included looked after children, children of substance misusing parents and young carers. Staff would attend child protection case conferences and serious case reviews where appropriate. Reports were sent to the GP if staff were unable to attend.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GP or practice nurse's attention, who then worked with other health and social care professionals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice nurse was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines which require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had established a service for patients to pick up their dispensed prescriptions at two locations and had reviewed systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed staff at the premises to be doing the best they could to keep it clean and tidy. We saw there were cleaning schedules in place. Individual cleaning records for each area/room were not kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection prevention and control. We noted the tiles behind the taps in the patient toilet were coming away from the wall.

An infection prevention and control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control the risk of infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection prevention and control policy.

Requires improvement

Are services safe?

Reception staff told us how they followed the procedure when accepting specimens from patients and used gloves when appropriate. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection prevention and control who had undertaken further training to enable them to provide advice on the practice policy and carry out staff training. All staff received induction training about infection prevention and control specific to their role and received annual updates. We asked to see a recent audit. The practice manager told us one had not been completed in the last two years.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We noted not all hand soap containers were wall mounted.

We asked to see a risk assessment or test for legionella (a bacterium which can contaminate water systems in buildings). We were told the test had just been completed and they were waiting for the results.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records confirming this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was March 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. DBS checks had recently been submitted for existing staff as they had worked at the practice for a number of years. The most recent member of staff joined the practice four years ago.

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 reception staff to ensure enough staff were on duty. The nurse appointments were arranged during their working hours at the practice. We noted there was no nurse cover during periods of leave. A locum GP covered the GP when they were on leave. The locum had worked at the practice for a number of years.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us reception records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included dealing with emergencies. Staff told us they would also verbally inform the practice manager if they identified any issues or risks. These were then dealt with in a timely manner. We were told any identified risks were discussed at practice meetings.

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We asked to see a fire risk assessment. We were told one had not been completed in the past 12 months. Staff told us the fire equipment was tested annually. Fire alarm tests and evacuation drills were not performed regularly. Records showed staff were up to date with fire training.

The appointments systems in place allowed a responsive approach to risk management. For example, when there were no appointments available for people who requested an urgent appointment on the same day, the GP would be informed and ring the patient back.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The practice had some arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. We noted oxygen and an automated external defibrillator, used to attempt to restart a person's heart in an emergency, were not available in the practice. We asked to see a risk assessment as to why the practice did not have these. We were told one had not been completed. All members of staff we spoke with knew the location of the other emergency equipment and records confirmed it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included adrenaline (which can be used to treat anaphylaxis); hydrocortisone (for treating asthma or recurrent anaphylaxis). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. 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 the utility companies if power was lost.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and shared with staff. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes had six monthly health checks and were referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital if needed.

The GP told us they led in specialist clinical areas such as heart disease and asthma and the practice nurse led on diabetic care. This allowed the practice to focus on specific conditions. Staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and their needs were being met. This assisted the reduction in the need for them to go into hospital. The number of patients with a long term condition who were admitted to hospital in an emergency was comparable to the local average of 13%. We saw following discharge from hospital, patients were followed up by the GP within three days to ensure all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP showed the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child safeguarding alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The GP showed us two clinical audits that had been undertaken in the last two years. They told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of stroke prevention medicines for patients with an irregular heartbeat. Following the audit, the GP carried out medication reviews for patients who were prescribed these medicines to ensure their medicines were aligned with national guidelines. All appropriate medicines were prescribed to the patient.

The practice also used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. The practice achieved 90% of the total QOF target in 2014, which was just below the local and national average of 94%. Specific examples included:

- Performance for diabetic care was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related conditions was slightly below the national average.

Good

Are services effective?

(for example, treatment is effective)

- The dementia diagnosis rate was below the national average

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting there was an expectation all clinical staff should undertake at least one audit a year.

Prescribing rates for the practice were lower than national figures for certain antibiotics. It was higher than the national average for the prescription of hypnotic medicines. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long term conditions such as diabetes and the latest prescribing guidance was being used. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GP would review the use of the medicine in question and, where they continued to prescribe it, outline the reason why they decided this was necessary.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, such as homeless people. Structured annual reviews were also undertaken for people with long term conditions. For example those with diabetes, chronic obstructive pulmonary disease (COPD) and heart failure.

The practice 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. This benchmarking data showed the practice had outcomes which were comparable to other services in the area. For example, prescribing antibacterial medicines.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. The GP was up to date with their yearly continuing professional development requirements and had been revalidated. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals which identified learning needs and action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example, a member of staff was completing further training in diabetic care.

The practice nurse had a job description outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, administration of vaccines and cervical cytology (cervical smear testing). They could also demonstrate they had appropriate training to review patients with long term conditions to fulfil these roles.

The practice manager told us where poor performance had been identified appropriate action would be been taken to manage this. They had no recent examples of where action had been taken.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of 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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by the GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within three days of receipt. 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.

Emergency hospital admission rates for the practice were comparable to the national average of 13%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up

Good

Are services effective?

(for example, treatment is effective)

patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw the policy for dealing with hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and no follow-ups were missed.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children who had a Child Protection Plan in place. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance service.

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

Consent to care and treatment

We found the GP was aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and had recently attended training. Staff we spoke with understood the key parts of the legislation and how they used it in practice. Staff told us what they would do in a situation if someone was unable to give consent, this included escalating it for further advice where necessary.

Clinical staff we spoke with demonstrated a clear understanding of Gillick competency and Fraser guidelines. These are used to assess whether a child under 16 has the maturity and understanding to make their own decisions and give consent to treatments being proposed.

Health promotion and prevention

It was practice policy to offer a health check 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. We noted a culture for staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients within two weeks if they had identified risk factors for disease at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 95% of patients with certain conditions and actively offered smoking cessation clinics to 86% of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 66%, which was below the local and national average of 76%. Practice staff told us they actively encouraged patients to attend for screening programmes when booking other appointments. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was comparable to the local area for the majority of immunisations where the data was available.

Practice staff showed us the resources available to patients experiencing poor mental health. This included voluntary sector agencies to promote independent living and

Good

Are services effective?

(for example, treatment is effective)

patients could be referred to primary care based talking therapies. Annual health reviews were offered to patients with severe mental health issues and the uptake was 87% which was comparable to the average of 86% for the local area. Patients were offered flexible appointment times avoiding booking appointments at busy times for people who may find this stressful.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in January 2015 completed by 79 patients (18% response rate).

The evidence showed patients were mostly satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated just below average for its satisfaction scores on consultations with doctors. For example:

- 73% said the GP was good at listening to them compared to the CCG average of 87% and national average of 88%.
- 73% said the GP gave them enough time compared to the CCG average of 86% and national average of 86%.
- 79% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 93%

Satisfaction scores for nurses were slightly above the average. For example:

- 85% said the nurse was good at listening to them compared to the CCG average of 80% and national average of 79%.
- 85% said the nurse gave them enough time compared to the CCG average of 81% and national average of 81%.
- 65% said they had confidence and trust in the last nurse they saw compared to the CCG average of 63% and national average of 63%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 10 completed cards and they all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. We noted curtains were not provided in the GP consulting room. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located in the room behind the reception desk which helped keep patient information private. Additionally, 98% said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

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

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, all of the respondents to the national GP patient survey said the last GP they saw was good or very good at explaining tests and treatments and involving them in decisions about their care.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. They had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and some reception staff and the GP spoke Arabic.

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 showed patients were positive about the emotional support provided by the practice. For example, patients told us staff responded compassionately when they needed help and provided them support when required. We were told by one patient how they had been supported emotionally by practice staff to come to terms with their illness. They were referred on to counselling to develop coping skills to manage their condition.

The national patient GP patient survey information we reviewed showed patients were less positive about the emotional support provided by the GPs. We noted only 74 surveys (18%) were returned. For example:

- 66% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86%
- 81% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 78%

Notices in the patient waiting room provided information for patients how to access a number of support groups and organisations. The patient record 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.

A mental health practitioner held a clinic in the practice once a week and patients told us how they valued this service providing them with support to manage their illness.

Staff told us if families had experienced bereavement the GP or nurse would contact 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.

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 patients' 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. A drop in clinic for children under the age of five was held once a week. Parents we spoke with told us the clinic was very convenient as appointment was not required and children could be given their immunisations whilst attending for another matter.

The NHS England Local Area Team and Clinical Commissioning Group (CCG) told us the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group. The group had identified parking for patients with limited mobility was an issue. The practice manager told us they were exploring the possibility of a disabled parking place outside the practice. Patients told us parking had improved since the occupiers above the practice had moved out.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The practice population was mainly English or Arabic speaking. Access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice was accessible to patients with mobility difficulties as facilities were all on one level. We noted the entrance was partially carpeted. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a waiting area with space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us they had some patients who were of "no fixed abode". They would be added to the appointment schedule if they came to the practice asking to be seen. There was a system for flagging vulnerability in individual patient records.

The full time GP was male. A female locum GP worked at the practice to cover annual leave. Patients told us they would like to have access to a regular female GP so they had choice who to see. The GP told us they were actively trying to recruit a female GP and a recent recruitment advert had been published.

Access to the service

The practice was open from 9am to 6.30pm Monday to Friday. Extended opening was available on Monday evenings until 8pm. Information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange urgent appointments and home visits and how to book appointments through the on-line patient record system. There were also arrangements to ensure patients received urgent medical assistance from 6.30pm until 9am. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the practice leaflet and on the website.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the local care home on a specific day each week and to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 82% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 79%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 89% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 79%.
- 62% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 56% and national average of 58%.
- 96% said they could get through easily to the surgery by phone compared to the CCG average of 74% and national average of 77%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a doctor on the same day if they felt their need was urgent. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a patient we spoke with told us they rang the surgery that morning for their child and was given an appointment an hour later with the GP.

Home visits were available for those people who needed them and longer appointments were offered if needed. Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people. Online appointment and repeat prescription requests were available and easy to use. Staff at the practice told us they worked closely with the local sexual health clinic. Staff at the practice worked closely with other organisations to understand the needs of the most vulnerable in the practice population. This included the local authority, local support groups and voluntary organisations.

Staff told us how they would avoid booking appointments at busy times for people who may find this stressful.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system in the practice leaflet and a notice in the waiting room area. 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.

We looked at two complaints received in the last 12 months and they were handled satisfactorily, dealt with in a timely way, and there was openness and transparency in dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 had a statement of purpose, staff spoke enthusiastically about working there and told us they felt valued and supported. Staff told us their role was to provide the best care to patients. We asked if the practice had developed an overall vision or practice values staff had taken time out to contribute to and staff told us this happened informally at the practice meetings where all staff contributed.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in files kept within the practice. We looked at 10 of these policies and procedures and all staff had completed a cover sheet to confirm they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually. We noted the recruitment policy referred to the Criminal Records Bureau. We fed back to the practice manager this had been replaced by the Disclosure and Barring Service. All other policies were up to date.

We spoke with five members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. The full time GP was the lead for safeguarding and staff could tell us this. The practice nurse took the lead for infection prevention and control.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing just below local and national standards. The practice achieved 90% of the available QOF points for the year 2013-14 compared to the CCG and national average of 94%. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We were not shown an on going programme of clinical audits; although we were shown the individual evidence they were taking place.

The practice had arrangements for identifying, recording and managing risks. Whilst we found evidence some aspects were good, we identified a number of areas where improvements were needed. For example, the practice had not made sure there were proper arrangements in place for assessing the risk of and controlling and preventing the spread of infections and fire prevention. The individual risks were regularly discussed at team meetings and incident forms updated in a timely way.

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

Leadership, openness and transparency

We saw from minutes, team meetings were held monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example, disciplinary procedures and the induction policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups and nationalities. The PPG had met every quarter. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice had also gathered feedback from staff at staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw regular

Are services well-led?

Good

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

appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff away days where guest speakers and trainers attended.

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

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 15 HSCA (RA) Regulations 2014 Premises and equipment We found the provider had not protected people against the risk of inappropriate or unsafe care and treatment, by means of maintaining the premises and equipment. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because: A fire risk assessment had not been completed in the last 12 months. Fire alarm tests and evacuation drills were not performed regularly. A recent (within the last 16 months) infection prevention and control audit had not been performed Regulation 15 1 (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.