Dr Abid Hamid

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Abid Hamid on 12th February 2015. Overall the practice is rated as good.

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

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, however monitoring the impact and changes required in light of the significant events was not recorded and learning was not routinely shared with staff.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should

Summary of findings

- Ensure all staff understand their roles and responsibilities in line with the Mental Capacity Act 2005.
- Ensure all staff understand Gillick competency when assessing young people under 16 years of age.
- Ensure following significant events and incidents they more formally monitor the impact and changes required and record and share the learning with staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated informally to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation, however we found that not all staff were clear of their roles and responsibilities in line with Mental Capacity Act 2005. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. There was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings.

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 population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. The practice work with other health and social care providers and with out of hours providers to ensure consistency of care.

The practice was responsive to the needs of older people, the GP and provided home visits and rapid access appointments for those with enhanced needs. It was practice policy should an elderly patient arrive at the practice without an appointment, reception staff should not to turn patients away but to try and accommodate the patient so they can see a Doctor without having to come back. The over 75yrs population are offered on the day appointments or telephone consultations.

We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable had care plans in place. Majority of the patients in this age group were from an Black and minority ethnic backgrounds where English was not there first language, when booking appointments for the over 75 care plans, reception staff ask if the patient would require a translator during the consultation and booking translators for the patients.

The practice is based in an area where the population is predominantly Asian and there are joint family systems in place and the elderly are cared at home by their extended family, the practice is proactive in recognising carers and recorded carer's details and gave support packs to the carers.

The practice had achieved 93% vaccination rate for the influenza vaccine.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so the condition can be monitored and reviewed. The practice have a high

Summary of findings

percentage of patients for who English is not their first language, all recall letters would be followed up by a telephone call to help patients understand the need to attend reviews. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours and Children with long term conditions appointments and reviews were accommodated with during school holidays.

The practice has produced a leaflet called keeping children and young people safe which is available to patients at reception desk.

The practice posts Pregnancy packs to women who are pregnant telling them of all the Antenatal clinics in the area and who midwifery team leaders are, the pack includes a leaflet on folic acid and has details of various workshops they can attend.

Due to English not being the first language the practice would contact newly pregnant patient and ask them if there is anything they do not understand and in majority of cases the practice would book antenatal appointment for them.

All of the staff were responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients including elderly health checks to patients who are 60 plus and not reached the age of 75. The practice had extended opening hour enabling people to make appointments outside normal working hours. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people where required. For patients where English was their second language, an interpreter could be arranged.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

The practice had held fortnightly clinics for patients experiencing drug and or alcohol issues run by a drugs counsellor

Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

Patients experiencing poor mental health are given telephone call reminders on the day of their appointment to ensure they attend there appointment, in the event patients do not want to come into the practice a home visit would be arranged for the patient.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients. We reviewed 27 CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 68% described their overall experience of this surgery as good and 81% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service SHOULD take to improve

Speaking with clinical staff they had an understanding of the principles of gaining consent but were not able to identify clearly their roles and responsibilities in line with the Mental Capacity Act 2005.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying potential risk. Staff we spoke with knew to report concerns and incidents. We reviewed significant events which had been recorded and saw that action had been taken however learning from incidents and a system to share learning with staff was not evident.

The nurse and health care assistant did not routinely see young people under 16 without a parent, but were able to outline Gillick competency when assessing young people under 16. However speaking with one GP they were unclear about Gillick competency, they told us this would be addressed as part of their professional development to ensure they were complying with good practice.

Dr Abid Hamid

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 specialist advisor and a Practice manager.

Background to Dr Abid Hamid

Dr Abid Hamid practice provides primary medical services in Rochdale from Monday to Friday. The practice is open between 8:30am and 6pm Monday, Thursday and Friday; Tuesday 8:30am to 8:00pm and Wednesday 8:30am to 3:00pm.

Dr Abid Hamid is situated within the geographical area of NHS Rochdale Clinical Commissioning Group (CCG).

Dr Abid Hamid is responsible for providing care to 4497 patients of whom, 54% were male and 46% were female. The practice had a higher than average child and working age population and lower than average percentage of patients over 75 years of age. Patients at the practice were predominantly from Black and minority ethnic groups accounting for 91% of total patients.

When the practice is closed patients were directed to the out of hours service.

The CQC intelligent monitoring placed the practice in band 4. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 12th February 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with six patients and six members of staff and Dr Abid Hamid. We spoke with a range of staff, including receptionists, the practice manager and practice nurse.

Detailed findings

We reviewed 27 Care Quality Commission comment cards where patients and members of the public had 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place to monitor patient safety utilising all the data and information available to them. Reports from NHS England indicated that the practice had a good track record for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as an achieving practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events.

A system to report, investigate and act on incidents of patient safety was in place, this included identifying

potential risk. Staff we spoke with knew to report concerns and incidents. We reviewed significant events which had been recorded and saw that action had been taken however learning from incidents and a system to share learning with staff was not evident.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

The practice had systems in place to respond to safety alerts, however action taken and outcomes was not recorded or audited.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care.

The practice had systems in place to maintain safe patient care of those patients over 75 years of age, with long term health conditions, learning disabilities and those with poor mental health. The practice maintained a register of patients with additional needs and or were vulnerable and closely monitored the needs of these patients, including regular contact with other health and social care professionals where required.

We saw patients who required annual reviews as part of their care; a system was in place to ensure reviews took place in a timely manner.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording significant events, We saw from the practice significant events records and speaking with staff investigations had been carried out however monitoring the impact and changes required in light of the significant events was not recorded and learning was not routinely shared with staff. All staff told us the practice was open and willing to learn when things went wrong and provided examples of where they had been supported following significant events such as a violent patient.

Staff told us they received updates relating to safety alerts they needed to be aware of via emails, however action taken and outcomes was not recorded or audited. The nurse told us they received regular updates as part of their on going training, and self-directed learning,

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure; we noted however there was no reference to the Mental Capacity Act 2005 within the adults safeguarding policy. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead, they had completed training to level three, working closely with the practice manager who linked with the Local authority we saw staff at the practice were knowledgeable about the contribution the practice could make to safeguarding patients. We were provided with examples of where staff had been proactive in safeguarding patients and worked alongside for example school health and social workers.

The practice had designed and made available to patients a safeguarding leaflet 'Keeping children and young people safe' which included national and local support information.

A chaperone policy was in place, Speaking with staff who acted as chaperones, they were clear of the role and responsibilities.

Good

Are services safe?

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by GPs were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was found to be clean and tidy. The health care assistant took the lead for infection control and carried out routine spot checks and audits to ensure the practice was complying with standards. All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

We saw staff had received infection control training; all staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

Cleaning and maintenance was managed by the building management as was clinical waste. The practice manager told us they met with the building management routinely and were able to raise any concerns as and when required.

The practice carried out an annual infection control audit; we saw the outcomes of the last audit in February 2015 and noted a high level of compliance.

We looked in four consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. We saw the dignity curtains in each room were disposable and were clearly labelled as to when they required replacing.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Good

Are services safe?

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place which was up-to-date We looked at the recruitment and personnel records of five staff. We saw recruitment checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice 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.

Identified risks were included on a risk log, reviewed and managed by the practice manager who liaised with the buildings manager where required.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us as they were such a small team, they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance form the Resuscitation council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the building management, CCG and associated health and social care professionals.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and regular fire drills were carried out by the buildings management.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Speaking with the practice nurses they explained to us how they reviewed patients with chronic diseases such as asthma on an annual basis, we saw from The national Quality Outcome Framework (QOF) 100% of the outcomes had been achieved for patients with asthma, Chronic obstructive pulmonary disease and Chronic kidney disease, were above the local CCG average.

Prior to the inspection we noted the outcomes for patients with diabetes were below the local and national average, in particular the number of diabetic patients with a high HbA1c (HbA1c refers to glycated haemoglobin, by measuring glycated haemoglobin (HbA1c), clinicians are able to get an overall picture of patients average blood sugar levels over a period of weeks/months. The higher the HbA1c the greater the risk of complications). Speaking with the GP and nurse they were aware of the issues and discussed the challenges of the population group in complying with healthy lifestyle advice due to cultural identity. The nurse provided us with a number of examples of patient education they were providing during consultation but raised concerns about the lack of diabetes education programmes and or access to health trainers in the community which were available to non English speaking patients. An action plan was in place to improve the outcomes for patients and we were told they were monitoring QOF data in year and improvements had been made.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks. All patients with learning disabilities had annual reviews carried out by the Health Care Assistant who explained to us they used the nationally recognised Cardiff Health Check to ensure a comprehensive review was carried out encompassing emotional and physical well being.

The GPs carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF provided evidence the practice were responding to the needs of people with poor mental health, above the average of the local CCG, by ensuring for example they had access to health checks as required such as, a record of alcohol consumption and body mass index (BMI) in the preceding 12 months.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy. For children of refugees or new into the country, where records were not clear and up to date for child immunisation, a policy was in place and guidance from the Health Protection Agency to ensure children attending the practice had access to appropriate vaccinations.

We saw from information available to staff, minutes of meetings and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and nursing staff told us they received regular updates as part of their on going training.

Clinical staff were unable to clearly describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. Multi-disciplinary care review meetings were held with other health and social care providers. We noted GPs had undertaken additional education programmes in relation to end of life care.

We were told for patients where English was their second language a face to face interpreter could be arranged within 24 hours, or immediately over the phone. For example patients aged over 75 when arranging an appointment to discuss their care plan, reception staff would establish in advance of the appointment if an

Good

Are services effective?

(for example, treatment is effective)

interpreter was required. This was in line with good practice to ensure people were able to understand treatment options available. The practice had access to a full range of language interpreters and we observed reception staff speaking with patients on the telephone and at reception in patient's first language.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or Chronic obstructive pulmonary disease (COPD). Assessments were carried out for patients with COPD and where required seasonal adjustments were made. During the winter months all patients were sent a prescription for medication to help when a patients was experiencing exhasibation. Patients received a letter explaining when the medication is to be used; this was also followed up with a telephone call to the patient to reinforce what the prescription is for.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice showed us how they monitored patient data which included full clinical audits taking place which demonstrated changes to patient outcomes. Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment.

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma and heart failure. They were also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 95.7% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement with 95.9% of outcomes achieved.

The practice had systems in place to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long term medication.

Patients told us they were happy the doctors and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors, nurse and health care assistant with a number having additional training and qualifications for example diabetes care, smoking cessation, end of life care and depression. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (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 practice and remain on the performers list with NHS England).

We noted the practice had a female GP providing a clinic once a week. However speaking with patients on the day of our inspection we were told of difficulties booking an appointment with the female GP. Speaking with the practice manager they were aware of the length of time to book an appointment with the female GP, however they had a high number of patients who do not attend (DNA) these appointments which had impacted on the length of wait. The practice were continuing to monitor the demand for the female GP and DNA.

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively.

The practice had an appraisal system in place for all staff. We saw appraisals were up to date.

Good

Are services effective?

(for example, treatment is effective)

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. We saw the nurse had access to training as part of their professional development, attending training and practice nurse events in which updates on key issues was provided.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. The GP and the practice manager arranged mutli-disciplinary meetings where required. Communication on a daily basis with community midwives, health visitors and district nurses took place by telephone and fax. The practice had identified difficulties contacting with health visitors and were working with the CCG to address this.

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 arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

For patients at the end of life the practice worked closely with the palliative care team and Macmillan nurses to ensure co-ordinated care was in place. Patients who required emotional support would be referred to counselling services.

For patients requiring support with alcohol or substance misuse the practice provided a fortnightly clinic delivered by a drug counsellor.

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. Electronic systems were also in place for making referrals, for example Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GPs on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and out of hour providers.

For the most vulnerable 2% (a nationally agreed percentage) of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their family.

Consent to care and treatment

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations.

There were no policies or procedure in place for staff to refer with regard to the Mental capacity Act 2005 (MCA) and staff had not completed any training. Speaking with clinical staff they had an understanding of the principles of gaining consent but were not able to identify clearly their roles and responsibilities in line with the Mental Capacity Act 2005 and were unable to describe how they implemented it in their practice. Speaking the GP they were aware the MCA was an area of development for the practice.

Good

Are services effective?

(for example, treatment is effective)

The nurse and health care assistant did not routinely see young people under 16 without a parent, but were able to outline Gillick competency, however speaking with one GP they were unclear of Gillick competency, they told us this would be addressed as part of their professional development to ensure they were complying with good practice.

We were shown forms for which consent other than implied consent would be recorded. This consent form, once signed would be scanned into patients' notes, this included vaccinations.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check.

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services and health promotion.

We were provided with details of how staff promoted healthy lifestyles during consultations. The clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 291patients were offered checks with 216 of patients took up the offer of the health check. The practice followed the guidance from the local CCG to ensure patients followed in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The nurse and health care assistant provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. The health care assistant provided an in-house smoking cessation service. The nurse described to us how they provided simple demonstrations of exercise patients could do in the home as a way of motivating and encouraging patients to take up exercise.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had provided 93% of patients over 65 with the flu vaccination during 2014 winter campaign, better than average.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough). We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

The practice's performance for cervical smear uptake was 80%, which was in line with national averages and slightly higher than the CCG average. There was a policy to offer telephone reminders for patients and follow up those who did not attend.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, the reception staff would make contact with patients to establish if the patient would like a telephone consultation or visit. Any patient aged 75 or known to be vulnerable would receive a telephone call from the GP on the day.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with six patients and reviewed 27 CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in reception and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw all phone calls from and to patients were carried out in a private area behind reception we were told this helped to maintain patient confidentiality. A system was in place to allow only one patient at a time to approach the reception desk, with signs asking patients to stand back allowing patients privacy, preventing patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms at the side of reception. All the patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff.

Looking at the results from the GP Patient Survey 2013, 71% of respondents found the receptionists at this surgery helpful. From the PPG survey carried out in November 2014 majority of patients rated the helpfulness of receptionists as good, very good or excellent.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones, modesty sheets to maintain patient's dignity.

We found all rooms had dignity screens or lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The patients told us they were happy to see the GP or the nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurse were patient, listened and took time to explain their condition and treatment options. The results from the National GP Patient Survey showed 96% of respondents had confidence and trust in the last nurse they saw or spoke to, however 49% of respondents stated the last GP they saw or spoke to was good at involving them in decisions about their care and treatment which is below the local CCG average. From the PPG survey carried out in November 2014 patients rated overall satisfaction with the practice as good 34%, very good 25% and excellent 26%.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 91.9% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. The nurse took the lead on developing care plans for those over 75 years of age with 54% completed all care plans were to be in place by March 2015. An interpretation service was available to support patient's involvement in the development of care plans. For those vulnerable patients at risk of unplanned hospital admissions had care plans in place and these were reviewed every three months. Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions.

We noted where required patients were provided with extended appointments for example reviews with patients with learning disabilities or multiple conditions to ensure they had the time to help patients be involved in decisions.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the National GP survey 72% of respondents stated the last GP they saw or spoke to was good at listening to them and 58% stated the last GP they saw or spoke to was good at treating them with care and concern.

The practice had identified within their patient population many families cared for elderly relative within the home and were proactive in identifying carers establishing a carer's register and providing carers with a support pack.

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team. Bereaved patients were visited by a GP and provided with 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.

The practice worked with patients and families and in a joined up way with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as accommodating home visits and booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice had a Patient Participation Group (PPG).The practice implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG examples included producing a practice newsletter.

Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice was on the second floor of a multipurpose building accessible by a lift or stairs. The practice was accessible for patients with disabilities and had disabled parking spaces available. A disabled toilet was available as were baby changing facilities. A hearing loop had been installed within the practice to support patients who were hard of hearing.

Translation services were available for patients and staff within the practice spoke a range of languages such as Urdu and were able to translate and receive telephone calls from patients for whom English was not their first language; we observed reception staff speaking with patients at reception and over the telephone in the patient's first language.

The practice provided extended appointments where necessary and appointments were available from 6:30pm to 8pm on a Tuesday to enabling people to make appointments out of normal working hours.

Access to the service

Appointments were available from 8:30am and 6pm Monday, Thursday and Friday; Tuesday 8:30am to 8:00pm and Wednesday 8:30am to 3:00pm. Patients were able to make appointments in advance, in person at reception, over the telephone or online. On the day emergency appointments were available by telephoning the practice. Where all appointments were filled, reception staff would take patients details which would be followed up by the GP and where required same day appointments or telephone consultations would be arranged.

For vulnerable patients an alert system was in place to ensure whatever time of day they phoned, if required a same day appointment should be provided. We were told all children under five would be seen on the day. We were told that on occasion older patients would walk into the practice for an appointment, wherever possible they would be seen by a GP.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Home visits were available for patients each day by telephoning the practice before 10am.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, 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.

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator. This also included appointments with a named GP or nurse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The majority of patients we spoke with were satisfied with the appointment system with the only concerns raised being access to appointments with a female GP. The practice were monitoring access and working with the PPG to address this issue as there was a high did not attend rate (DNA) during the weekly surgery with the female GP. We saw from the National GP survey 63% were able to get an appointment to see or speak to someone the last time they tried and 76% say the last appointment they got was convenient. Results from the practice survey carried out in November 2014 showed, when asked to rate the length of time you had to wait for an appointment majority rated fair (29%) and good (30%).

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented however we did not see any documented evidence of lessons learnt being shared with staff or discussed during practice meetings. Speaking with the practice manager they told us they would include evidence of lessons learnt in the future and minute in meetings where appropriate.

Complaints information was available in the practice leaflet in the waiting area and on the website. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

A comments and suggestion box was available for patients to provide on-going feedback and the practice

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 clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's aims and objectives and statement of purpose. These values were clearly displayed on the practice website. The practice vision and values included, to provide personalised, effective and high quality general practice services, committed to the healthcare of all our patients and treat all patients and staff with dignity, respect and honesty. Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality. We saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with six members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw these were up to date and reflected current guidance and legislation.

There was a clear leadership structure with named members of staff in lead roles. For example, the health care assistant was lead for infection control and the GP was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw the practice made use of data provided from a range of sources including the Clinical Commissioning group (CCG), General Practice Outcome Standards (GPOS) and the national patient survey to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them, using the data to improve outcomes for patients and work with the local CCG. The practice also used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

The Practice manger and lead GP met on a regular basis to discuss practice issues, significant events and complaints. Where required multi–disciplinary meetings with external health and social care professionals were arranged. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken, for example antibiotic prescribing and patients attendance at Accident and Emergency and the Urgent Care Centre.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place however this was not always clearly documented.

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

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings and there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and procedures, for example, a recruitment policy and induction programme were in place to support staff. We were shown the staff handbook that was available to all

Are services well-led?

Good

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

staff, this included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, PPG surveys, suggestion box, compliments and complaints.

We saw that there was a complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions documented however there was no formal evidence of learning being shared with staff.

We reviewed the results of the national patient survey carried out in 2013/14 and noted 68% described their overall experience of the practice as good. The practice also carried out annual surveys. Analysis of the last internal patient survey in November 2014 showed, 34% stated good, 22% very good and 23% excellent when asked to rate overall satisfaction with the practice.

The practice had a Patient Participation Group (PPG) which was made up of a diverse range of patients. The PPG meet on a regular basis to review the findings from surveys and to discuss ways in which patient experience could be improved. We were provided with the analysis of the last patient survey and an action plan, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice made available to patients a newsletter, providing patients with information such as the number of missed appointments, repeat prescriptions and information for carers.

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.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development opportunities.

The practice had reviewed significant events and other incidents and shared with staff informally.