Dr Z Ahmad & Partners

Inspection report

Gardenia Surgery
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Date of inspection visit: 10/04/2018
Date of publication: 21/05/2018

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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous inspection 11/2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Dr Z Ahmad & Partners on 10 April 2018. 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, as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice displayed a good understanding of the duty of candour.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Some areas of practice performance were below local and national averages. However, the practice had identified the reasons for this and developed comprehensive action plans to make improvements.
- The practice referred patients to expert patient programmes to help them manage their conditions. For example, patients with type 2 diabetes were referred to the DESMOND programme. (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed. Patient education for people with diabetes.)
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The facilities and premises were appropriate for the services delivered. At both the main practice and the practices branch site, the consultation and treatment rooms were on the ground floor and access enabled toilets were available.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice worked to secure and keep services local for patients. For example, they started a long-acting reversible contraceptive (LARC) service after negotiating with the Luton Borough Council to secure funding.

The areas where the provider **should** make improvements are:

- Complete an action plan to address the areas in need of improvement found in the infection prevention and control (IPC) audit.
- Implement the identified actions to make improvements to the quality and outcomes framework (QOF) monitoring of patients.
- Consider formal training for reception staff to help them identify 'red flag' sepsis symptoms.
- Review patient satisfaction in response to the practice opening hours.
- Consider ways to further identify and support patients who are also carers.

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

Population group ratings

Older people	Good
People with long-term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Our inspection team

A CQC lead inspector led our inspection team**.** The team included a GP specialist adviser, and a practice manager adviser.

Background to Dr Z Ahmad & Partners

Dr Z Ahmad & Partners provides a range of primary medical services to the residents of Luton. The practice has a registered manager in place. A registered manager is an individual registered with CQC to manage the regulated activities provided.

The practice provides primary medical services under a general medical services (GMS) contract from its purpose built location of Gardenia Surgery, 2a Gardenia Avenue, Luton LU3 2NS and its branch practice of Marsh Farm Medical Centre, The Purley Centre, Luton, LU3 3SR. We visited both sites as part of the inspection. Online services can be accessed from the practice website

The practice has approximately 12,500 patients. The practice population is of mixed ethnicity with an average age range. National data indicates the area is one of mid to high deprivation.

The practice is led by three GP partners, all male and they employ one female salaried GP. They use three regular GP locums, one male and two female, to support the clinical team. The nursing team consists of a nurse practitioner and three general practice nurses, all female. They also employ a part-time pharmacist, female and a part-time locum pharmacist, male. There is a team of administrative and reception staff and a phlebotomist all led by the practice manager.

Dr Z Ahmad & Partners is open at Gardenia Surgery on Monday to Friday from 8.45am until 6.00pm (5.00pm on Wednesdays) and at Marsh Farm Medical Centre on Monday to Friday from 8.45am until 6.00pm (5.00pm on Thursdays). A duty GP can be contacted via the telephone from 8am to 8.45am and from 6pm to 6.30pm Monday to Friday in case of an emergency.

When the practice is closed out-of-hours services are provided by Herts Urgent Care and can be accessed via the NHS 111 service.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for their role and had received a DBS check. (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 who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was a system to manage infection prevention and control (IPC). A member of the nursing team was the IPC lead.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The practice had undergone significant changes to staffing over the previous two years. Experienced staff had left and the patient list size had increased. The GP partners met regularly to review the staffing structure. Administration staff were trained to undertake various roles to ensure there was always cover available for staff absences.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Prompts on the patient computer record system indicated when potential symptoms of sepsis were displayed.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues. For example, control of substances

hazardous to health and infection control, fire and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Are services effective?

We rated the practice and all of the population groups as good for providing effective services.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

The most recent published QOF results showed the practice achieved 83% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 96%. The overall exception reporting rate was 16% compared with the CCG average of 12% and the national average of 10%.

The practice informed us of the factors that had an impact on the QOF achievement over the previous two years. For example,

- A GP practice in the area closed and Dr Z Ahmad & Partners negotiated with the CCG and NHS England to receive an allocation of 2000 additional patients from September 2016 to January 2017. Time was taken to register these patients and establish them with an allocated GP.
- A number of senior staff retired including the practice manager, the senior practice nurse and the health care assistant.

The practice have now replaced the staff that had retired. A new practice manager commenced employment with the practice at the time of the inspection. To improve on QOF scores in the future, the practice shared with us a comprehensive action plan that included all members of the practice team.

- Monthly QOF meetings for the whole team were planned with additional weekly meetings for the GP partners and the practice manager.
- Members of the clinical team were allocated a lead role for different disease areas with actions and targets, For example, how many patients should be reviewed per month to achieve optimal results.
- There were plans to review the appointment system with a focus on availability of advance appointments to improve access.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary, they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice offered flu, pneumococcal and shingles vaccines to this age group.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The GPs and nursing staff had lead areas for managing patients with long-term conditions. Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Are services effective?

- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Patients were referred to expert patient programmes to help them manage their conditions. For example, patients with type 2 diabetes were referred to the DESMOND programme. (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed. Patient education for people with diabetes.)
- The practice were below clinical commissioning group (CCG) and national averages for the care of patients with some long-term conditions, for example, diabetes. Please see the evidence table for further details. In order to rectify this, the practice had formed an action plan to ensure patients with diabetes received an appropriate review of their condition. Specific appointments were identified and kept free for these patients. A set number of patients were to be called to the practice each week to ensure all patients were seen within one year. Staff were encouraged to opportunistically remind patients of the need for a review, for example, when they collected prescriptions or attended the practice for other appointments.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to children aged two were below the target percentage of 90% or above. As part of the review and action plan for the practice performance it had been identified that more appointment times could be made available for the practice nurses to help achieve the 90% uptake target.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Health visitors were invited to the monthly multi-disciplinary team meetings.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 67%, which was below the 80% coverage target for the national screening programme. The achievement was comparable with the CCG average of 66% and the national average of 72%. The practice had recognised that they needed to improve the uptake for cervical screening. As part of their action plan to improve QOF outcomes, they informed us they proposed to have a weekly evening clinic for cervical screening that would be convenient for patients who worked during normal surgery times.
- The practices' uptake for breast and bowel cancer screening was in line the national average. For example,
- - 72% of females, aged 50-70 years, were screened for breast cancer in last 36 months compared to the CCG average of 69% and the national average of 70%.
  - 47% of patients, aged 60-69 years, were screened for bowel cancer in last 30 months compared to the CCG average of 47% and the national average of 55%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including the housebound and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice nurses visited housebound patients to administer vaccinations and refer on to other services for health reviews, such as, District Nurses and Phlebotomists.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity,

obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. We were informed that patients who had attended secondary care, including attendances as a result of self-harm and suicide attempts were followed up and reviewed.
- 77% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This was comparable to the national average of 84%.
- 66% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the national average of 90%.
- The practice considered the physical health needs of patients with poor mental health and those living with dementia. For example, 72% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was below the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected, there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example,

- A programme of clinical audit was in place that included the review of patients who were prescribed high-risk medicines.
- The practice had undertaken two additional clinical audits in the past year. One of these was a completed audit that demonstrated quality improvement in the monitoring of patients who were prescribed a medicine used to treat certain mental health conditions.
- Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long-term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision-making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long-term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. Patients were referred to an organisation called Live Well Luton for lifestyle advice that included diet, weight management and smoking cessation.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision-making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable with others both locally and nationally for its satisfaction scores on consultations with GPs and nurses.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Interpretation services were available for patients who did not have English as a first language.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- Results from the July 2017 annual national GP patient survey showed how patients felt they were involved in decisions about their care and treatment. The practice was comparable with others both locally and nationally

Privacy and dignity

The practice respected/did not respect patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

Please refer to the Evidence Tables for further information.

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services .

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests and advanced booking of appointments.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. At both sites the consultation and treatment rooms were on the ground floor and access enabled toilets were available.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- SMS text messaging was used to send reminders to patients of their appointment times.

Older people:

- The practice had dedicated personal lists of patients for all the GP partners. This provided continuity of care that took into account the patient and the immediate family circumstances and ensured all patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice provided GP services to a local care home. This included weekly visits and home visits as required.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. The practice had a register of 'looked after children' which was reviewed as part of their safeguarding processes.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Appointments were available outside of school hours.
- The premises were suitable for children and babies. Baby-changing facilities were available.

Working age people (including those recently retired and students):

- The needs of this population group 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 promoted a full range of health promotion and screening that reflects the needs for this age group.
- Online appointment booking and repeat prescription requests were available.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including the housebound and those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode.
- The practice nurses visited housebound patients to administer vaccinations.

Are services responsive to people's needs?

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was in line the local and national averages in most areas. However, they were below average for the percentage of respondents who were 'Very satisfied' or 'Fairly satisfied' with their GP practices opening hours.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the practice had identified a need for the reception staff to receive training to reduce telephone call times. This was to improve access for patients to the practice via the telephone following a number of complaints regarding long wait times when contacting the practice. The practice had created a call centre in a room away from the reception desk for telephone calls to be answered to help reduce call-waiting times.

Please refer to the Evidence Tables for further information.

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They informed us that the practice was a good place to work.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- All staff were involved in making improvements within the practice. For example, all levels of staff were identified to make a contribution to the quality and outcomes framework (QOF) action plan.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Online training was available and accessible for all staff members.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. They had received appropriate training and could demonstrate when and how they would raise concerns.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Policies and procedures were available and accessible to all staff at both sites.

Are services well-led?

Managing risks, issues and performance

There were clear and effective clarity around processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. A business continuity plan was available and held off site by the GP partners.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Please refer to the Evidence Tables for further information.