# Dr Narendra Patel

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as requires improvement overall. (**We previously inspected this practice on 14 January 2015 and rated it as Good overall.)

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires improvement

People with long-term conditions – Requires improvement

Families, children and young people – Requires improvement

Working age people (including those recently retired and students – Requires improvement

People whose circumstances may make them vulnerable – Requires improvement

People experiencing poor mental health (including people with dementia) - Requires improvement

We carried out an announced comprehensive inspection at Dr Narendra Patel on 15 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had systems to keep patients safe and safeguarded from the risk of abuse however, policies did not reflect the most up to date guidance and not all staff had received appropriate safeguarding training.
- The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. The practice was the fourth lowest prescriber of antibiotics within the Clinical Commissioning Group.
- Protocols for the care of patients with diabetes or asthma had not been updated to reflect current National Institute for Health and Care Excellence (NICE) guidelines.
- Patients with long term conditions were offered an annual review of their health. However data showed

# Summary of findings

that care and treatment provided for patients with conditions, such as asthma, high blood pressure or diabetes, and patients experiencing poor mental health were below local and national averages.

- The practice had a system in place to monitor training completed by staff. Some staff had not received mandatory training as identified by the practice.
- Some clinical staff had not received training specific to their role to support them in providing appropriate treatment for people who lacked mental capacity.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice had only identified two patients as carers (0.1% of the practice list). They planned to work with the Age UK co-ordinator to increase their identification of carers.
- Patients were highly complementary regarding the care and treatment they received from the practice. The national patient survey rated the practice as the leading practice in the region for patient satisfaction and it ranked 52nd out of 7,000 practices nationwide.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The practice's complaints leaflet was out of date and was not readily available for patients to refer to. A complaint had not been dealt with in line with their own complaints policy.
- Staff stated they felt respected, supported and valued and there was an open culture within the practice, however systems for reporting and learning from significant and complaints were not always followed.
- There were clear responsibilities and roles of accountability. However, structures, processes and systems to support good governance and management were not clearly set out or effective.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate training necessary to enable them to carry out their duties.

For details, please refer to the requirement notices at the end of the report.

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

- Implement systems to proactively improve the identification of carers registered with the practice.
- Update their practice complaints leaflet and ensure it is readily available for patients to refer to. Ensure that all complaints are dealt with in line with their own complaints policy.
- Review access arrangements for disabled patients through the front door.

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

# 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** | **Requires improvement** |
| **People with long term conditions** | **Requires improvement** |
| **Families, children and young people** | **Requires improvement** |
| **Working age people (including those recently retired and students)** | **Requires improvement** |
| **People whose circumstances may make them vulnerable** | **Requires improvement** |
| **People experiencing poor mental health (including people with dementia)** | **Requires improvement** |

# Summary of findings

## Areas for improvement

**Action the service MUST take to improve**

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate training necessary to enable them to carry out their duties.

For details, please refer to the requirement notices at the end of the report.

**Action the service SHOULD take to improve**

- Implement systems to proactively improve the identification of carers registered with the practice.
- Update their practice complaints leaflet and ensure it is readily available for patients to refer to. Ensure that all complaints are dealt with in line with their own complaints policy.
- Review access arrangements for disabled patients through the front door.

# Dr Narendra Patel

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a CQC lead inspector**.** The team included a GP specialist adviser and an expert by experience.

## Background to Dr Narendra Patel

Dr Narendra Patel is registered with the Care Quality Commission (CQC) as a single handed provider and is located in Betley near Crewe, Cheshire. It is a rural practice providing care and treatment to approximately 1,872 patients of all ages. The practice offers dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. The practice holds a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice area is one of low deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. Demographically the practice has a lower than average young population with 14% of patients being under 18 years old compared with CCG average of 18% and national average of 21%. Twenty-eight per cent of the practice population is above 65 years which is higher than the CCG average of 21% and the national average of 17%. The percentage of patients with a long-standing health condition is 50% which is lower than the local CCG average of 57% and national average of 53%.

The practice staffing comprises of:

- One male GP
- Two practice nurses
- A practice manager
- Five members of administrative staff and dispensers working a range of hours.

Dr Narendra Patel is open between 8.30am and 6pm Monday to Friday except Thursday afternoon when it closes at 12.30pm. GP appointments are from 9am to 11am every morning and 4pm to 5.30pm except Thursday when the practice is closed. Pre-bookable appointments can be booked up to three months in advance and urgent appointments are available for those that need them. Telephone consultations are also available to suit the needs of the patient. The practice has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

The practice offers a range of services for example, management of long term conditions, child development checks and immunisations and travel immunisations. Further details can be found by accessing the practice's website at www.betleysurgery.nhs.uk

Requires improvement

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as requires improvement for providing safe services.**

The practice was rated as requires improvement for providing safe services because:

- Safety policies were undated or dated incorrectly meaning staff could not be sure they accessed the most recent policies for guidance and support. The policy for safeguarding vulnerable adults did not reflect updated categories or definitions of the types of abuse or outline who to go to for further guidance.
- Staff recruitment checks did not meet legal requirements. Reception staff who chaperoned had not been subject to Disclosure and Barring Service (DBS) checks. A risk assessment to mitigate potential risks to patients had not been completed. A system to monitor professional registrations were in date was not in place.
- Not all members of staff were aware of where the emergency medicines were stored.
- Systems to monitor cervical screening results were received and acted upon were not effective.
- Not all staff who monitored the temperature of the medicine fridge were aware of the manufactures' temperature range guidelines.
- Guidelines for the receiving of controlled medicines into the practice were not always followed.
- Action plans or action to mitigate risks identified in the fire and legionella risk assessments had not been completed.
- Opportunities to identify, analyse, learn and identify trends in significant events were not always taken.
- Processes to act on alerts were not always followed.

### Safety systems and processes

The practice had systems to keep patients safe and safeguarded from the risk of abuse however, policies did not reflect the most up to date guidance and not all staff had received appropriate training.

- There was a suite of safety policies but many of them were undated or dated incorrectly, such as 2018. This meant that staff could not be sure they accessed the most recent policies for guidance and support. An undated health and safety policy was available for staff to refer to within the practice and this was shared with staff at the time of their induction. All staff had received fire training however, staff members had not received training in general health and safety.
- The practice had limited systems to safeguard children and vulnerable adults from the risk of abuse. Safeguarding policies were accessible to staff however, there was no evidence to demonstrate they were regularly reviewed. We saw that the safeguarding policy for vulnerable adults did not reflect updated categories or definitions of the types of abuse for example, modern slavery. The policies did not outline who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and the risk of abuse. Staff took steps to protect patients from the risk of abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff recruitment checks, including evidence of satisfactory conduct in previous employment and health assessments. Disclosure and Barring Service (DBS) checks were undertaken for clinical staff. (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). However, reception staff who acted as chaperones were trained for the role but had not received a DBS check. A risk assessment had not been completed to mitigate any potential risks. We found unexplained gaps in staff employment histories and there was no system in place to monitor that professional registrations were in date.
- There was an effective system to manage infection prevention and control and an undated policy for staff to refer to for guidance and support. An infection control audit had been completed showing a 94% compliance rate. Staff had received recent training in infection control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Requires improvement

# Are services safe?

## Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. However, the long term locum GP who provided cover when needed had recently retired. Succession planning to ensure locum GP cover would be available had not been carried out.
- There was an induction system for temporary staff tailored to their role however this had not been updated for three years.
- 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, for example, sepsis. Reception staff had guidelines to support them to recognise rapidly deteriorating patients. However, some members of staff were not aware of where the emergency medicines were kept should they be required.

## Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice used patient special notes to share information with the out of hours service.
- Referral letters included all of the necessary information.
- There was a system in place to monitor cervical screening results were received and acted upon. We reviewed the system and saw that a result for a patient who had received a cervical smear six months earlier had not been received. Action to chase it up had not been completed. The practice informed us after the inspection the result had been obtained sixteen days after the test but their spread sheet for monitoring had not been updated to reflect this.

## Safe and appropriate use of medicines

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

- The systems for managing medicines, medical gases, and emergency medicines and equipment minimised risks. We saw that medicines requiring refrigeration were stored according to manufactures' guidelines. However, staff who monitored the temperature of the fridge when a practice nurse was not available were not aware of the temperature range guidelines in which these medicines must be stored. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe. However, the practice did not always follow their own guidelines when receiving controlled medicines into the practice, For example, the practice's standard operating procedure for the receiving of controlled medicines into the practice stated they should be checked by two authorised personnel. However, on the day of our inspection we saw this was carried out by just one authorised person.

## Track record on safety

- The practice had conducted a limited amount of safety risk assessments. For example, an in house legionella risk assessment and fire risk assessment. However, where issues were identified action to mitigate risks had not always been implemented. For example, the fire risk assessment identified there was no emergency lighting or fire alarm system in the practice. An action plan to mitigate these risks had not been developed or implemented. The legionella risk assessment highlighted the need to monitor the water temperature but there were no records to demonstrate that this had been completed.

Requires improvement

# Are services safe?

- The practice monitored and reviewed activity within the premises. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements within the building.

### Lessons learned and improvements made

The practice had systems in place to learn and make improvements when things went wrong, however they were not always implemented.

- There was a significant events policy to support staff to record and act on significant events and incidents. Staff we spoke with were aware of their role in raising and reporting significant events. However, the policy was dated 2018 and the audit sheet to demonstrate it had been shared with staff had only been signed by the GP. The practice informed us there had been no significant events during the previous 12 months. We saw that the practice used near miss forms to record dispensing errors but learning from these was not always clear and there was no analysis of trends.
- A clear process in regard to the receipt, analysis and response to Medicines and Healthcare products Regulatory Agency (MHRA) was not in place. The practice's process to act on these alerts was not always followed. We saw evidence that some of these alerts had been acted upon but found gaps where the process had not been followed. For example, the GP was not aware of a MHRA alert issued in September 2017 that highlighted risks regarding the combined use of two medicines for the treatment of fungal infections of the mouth, throat, stomach or intestines. There was no evidence that searches of patients' records had been carried out in response to a MHRA alert regarding to the use of a medicine used for patients with diabetes. The practice told us that they knew they did not have any patients on this medicine so there was no need to carry out a search. Following our inspection the GP informed us that the practice manager would also receive the alerts to ensure more than one person had sight of them.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice, and all of the population groups, as requires improvement. However, we also found examples of good practice which is reflected in the population groups below.**

The practice was rated as requires improvement for providing effective services because:

- Protocols for the care of patients with diabetes or asthma had not been updated to reflect current National Institute for Health and Care Excellence (NICE) guidelines. However, the GP had identified this as a need in their appraisal.
- The Quality Outcome Framework (QOF) results for 2016/17 showed that care and treatment provided for patients with long term conditions, such as asthma, high blood pressure or diabetes, and patients experiencing poor mental health were below local and national averages. Their exception reporting of patients with asthma or patients experiencing poor mental health was significantly higher than local and national averages.
- Some staff had not received mandatory training as identified by the practice.
- Some clinical staff had not received training specific to their role to support them in providing appropriate treatment for people who lacked mental capacity.

### Effective needs assessment, care and treatment

Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance. Although they were aware of the guidance we found examples where guidance had not been fully reviewed and care updated accordingly:

- The practice were aware of the NICE guidelines to ensure that patients' needs were fully assessed and care and treatment was delivered in line with national guidelines. However, some protocols had not been updated to reflect updated NICE guidance. For example, protocols for the care of patients with diabetes or asthma.
- Data from electronic Prescribing Analysis and Costs (ePACT) indicated that the prescribing rate for hypnotics (medicines used to aid sleep) was comparable with other practices showing that the practice was following national and local guidance. ePACT is a system which allows authorised users to access prescription data.
- ePACT data showed that the percentage of broad spectrum antibiotics, that can be used when other antibiotics have not been effective, was 1.4%. This was lower than the Clinical Commissioning Group (CCG) average of 4% and the national average of 4.7%. It is important that this group of antibiotics are used sparingly to avoid medicine resistant bacteria developing and indicates that the practice was following national and local guidance. Recent data from the CCG showed that out of 32 practices this practice was the fourth lowest prescriber of antibiotics within the CCG.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice offered an ambulatory blood pressure home monitoring service. However, a protocol to monitor and support this was not in place and the overall impact and effectiveness of this service had not been documented or audited.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice had been effective in reducing the number of Accident and Emergency (A&E) attendances and unplanned hospital admissions for patients of all ages. Data collated by the CCG showed over a rolling 12 month period the rate per 1000 of patients who attended A&E had fallen from 190 to 169. The rate of unplanned hospital admissions with a length of stay less than two days had fallen from 55 to 47 patients per 1000.

Older people:

- A facilitator from Age UK worked with the practice to provide an assessment of the social needs of patients over 80 years old.
- The manager from a nearby care home told us that the GP provided flu immunisations at the home for patients who lived there.
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

- The practice had been effective in reducing the number of Accident and Emergency (A&E) attendances and unplanned hospital admissions for patients aged 75-84 years. Data collated by the CCG showed over a rolling 12 month period the rate per 1000 of older patients who attended A&E had fallen from 339 to 187. The rate of unplanned hospital admissions with a length of stay less than two days had fallen from 135 to 53 patients per 1000.
- The practice held quarterly meetings with the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss and manage the needs of frail older patients or patients with complex medical issues.
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed 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.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The Quality Outcome Framework (QOF) results for 2016/17 showed that care and treatment provided for patients with long term conditions, such as chronic obstructive pulmonary disease and those at risk of moderate to high risk of stroke were in line with local and national averages. QOF is a system intended to improve the quality of general practice and reward good practice. However, results for patients with asthma, high blood pressure or diabetes were lower:
- 52% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma. This was below the CCG average of 77% and national average of 76%. Their exception reporting rate of 33% was significantly higher than the CCG average of 9% and national average of 8%.

  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 percentage of patients with diabetes, on the register, whose last blood pressure reading that was within normal limits was 58%. This was lower than the CCG average of 80% and the national average of 78%. Their exception reporting rate of 6% was comparable with the CCG and national averages of 9%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol was within recognised limits was 69%. This was below the CCG average of 81% and the national average of 80%. However, their exception reporting rate of 4% was lower than the CCG average of 14% and national average of 13%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was within recognised limits was 74%. This was below the CCG average of 84% and national average of 83%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates of 100% for the all childhood vaccines given were above the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for the cervical screening programme was 80%. This was comparable with the CCG average of 82% and the national average of 81%. Their exception reporting rate of 2% was lower than the CCG average of 5% and the national average of 8%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice provided opportunistic NHS checks for patients aged 40-74.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances includingthose with a learning disability and those who were frail.
- The practice provided annual health checks for patients with a learning disability.

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

- 82% of patients diagnosed with dementia had a care plan in place that had been reviewed in a face-to-face review in the preceding 12 months. This was comparable with the CCG average of 85% and the national average of 84%. Their exception rate of 11% was comparable with the CCG average of 8% and the national average of 7%.
- 33% of patients with a diagnosed mental health disorder had a comprehensive, agreed care plan documented in their record, in the preceding 12 months. This was below the CCG average of 91% and the national average of 90%. Their exception reporting rate of 31% was higher than the CCG and national averages of 13%.
- The practice was not proactive in considering the physical health needs of patients with poor mental health and those living with dementia. 50% of patients with a diagnosed mental health disorder had their alcohol consumption recorded in their notes in the preceding 12 months. This was lower than the CCG average of 92% and national average of 91%. However, their exception reporting rate of 23% was significantly higher than the CCG average of 9% and national average of 10%.

### Monitoring care and treatment

The practice had a programme of quality improvement activity, reviewed the effectiveness and appropriateness of the care provided. However, they did not always formally document it to demonstrate the improvements they had made to patient care. For example, an audit to identify patients with impaired fasting blood sugar levels had been completed. It identified that four patients had not been coded or followed up and a repeat audit would be carried out in 12 months. We saw that the four patients had been followed up but it was not documented to formally demonstrate the improved outcomes for patients and the positive learning from the changes made. Where appropriate, clinicians took part in local and national improvement initiatives. For example, assessment and support for older, frail patients.

The most recent published QOF results were 80% of the total number of points available which was lower than the CCG average of 97% and national average of 96%. We saw that the QOF results for a number of indicators (asthma, diabetes and poor mental health and high blood pressure) were lower than the CCG and national averages. We explored these results with the GP during the inspection. They told us this was due to the small number of patients, patients did not always comply with treatment or patients did not always attend health reviews. They told us they had started to recall patients who did not attend their health reviews much sooner to ensure they were followed up quicker. The practice felt confident that the changes they had made would improve the outcomes for these patients.

Their overall clinical exception reporting rate was 6% compared with the CCG and national averages of 10%. We saw that the exception rates for a number of clinical domains (asthma and poor mental health) were significantly higher than the CCG and national average. We explored this with the GP during the inspection. They explained that patients who declined or did not respond to invitations to attend a review of their condition three times were exception reported. By recalling them earlier they were hopeful this rate would decrease over the next 12 months.

### Effective staffing

Most staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included 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 and support for revalidation.

However, we found some staff had not received mandatory training as identified by the practice:

Requires improvement

# Are services effective?

## (for example, treatment is effective)

- Staff had not received training in general health and safety and only the practice manager had received training in equality and diversity.
- Two members of non-clinical staff had not received training in safeguarding children and three members of staff (clinical and non-clinical) had not received training in safeguarding vulnerable adults. The GP lead for safeguarding last received training in safeguarding vulnerable adults in March 2013.

### Coordinating care and treatment

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

- Appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. For example, the ILCT team.
- 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.
- We spoke with the manager of a nearby care home who told us that the practice was effective and responsive in providing care for patients in the home. The practice worked with the home to ensure that residents received an annual flu immunisation. The practice also worked closely with the home to ensure 'do not attempt cardiopulmonary resuscitation' (DNACPR) plans were reviewed regularly for patients nearing the end of their life.

### Helping patients to live healthier lives

Staff helped some 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 at risk of developing a long-term condition, patients with a learning disability and frail older patients. However, a proactive system to identify patients who were carers was not in place although they had plans to address this by working closely with the Age UK co-ordinator.
- The practice was effective in referring patients with possible cancer. Data from Public Health England showed that 50% of new cancer cases (among patients registered at the practice) were referred using the urgent two week wait referral pathway. This was comparable with the CCG average of 59% and the national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, tackling obesity and screening for breast and bowel cancer. Seventy-eight per cent of eligible women had been screened for breast cancer in last 36 months compared with the national average of 73%. Sixty-three per cent of eligible persons had been screened for bowel cancer in last 30 months compared with the national average of 58%.

### Consent to care and treatment

Clinicians demonstrated an understanding of the requirements of legislation and guidance when considering consent and decision making. For example, when providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. However, the GP responsible for the care of patients with dementia and reviewing of the DNACPR plans had not received training or updates in the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards to support their knowledge and understanding. We could not be reassured that they were up to date in respect of legal changes in this area or their responsibilities in achieving them.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could take them to a private area in the practice. There was a sign at the reception desk informing patients of this.
- We received 48 patient Care Quality Commission comment cards. All were extremely positive about the care and treatment experienced. This was in line with comments from the 15 patients we interviewedon the day of our inspection. Patients told us staff were helpful, polite, caring and respectful. All of the patients were highly complementary regarding the care provided by the GP many stating that nothing was too much trouble for him.
- Prior to our inspection we spoke with two members of the virtual patient participation group (VPPG). They told us that the practice listened to and respected the views and concerns of the VPPG.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and eight surveys were sent out and 124 were returned. This represented approximately 6.6% of the practice patient population. The practice was above average for all of its satisfaction scores on consultations with GPs and nurses. The results also showed that the practice was the leading practice in the region for patient satisfaction and ranked 52nd out of 7,000 practices nationwide. Data showed:

- 97% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 98% of patients who responded said the GP gave them enough time compared with the CCG average of 89% and the national average of 86%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%.
- 96% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 87% and the national average of 86%.
- 96% of patients who responded said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 96% of patients who responded said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 96% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 97% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 87% and the national average of 87%.

### Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand. The practice had access to a sign language interpretation service and were exploring purchasing a hearing loop for patients with impaired hearing.

Good

# Are services caring?

- Staff helped patients to find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice was not proactive in identifying patients who were carers and had only identified two carers (0.1% of the practice list). The GP identified carers however the practice were working with Age UK to identify other patients who were carers. The practice's computer system alerted staff if a patient was a carer.

If families had experienced bereavement, the GP contacted or visited them. The GP worked with Age UK to support bereaved patients and gave advice on how to find a support service.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were consistently above local and national averages:

- 96% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 83% and the national average of 82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

These results were supported by the comments made by patients on the day of our inspection. Patients described the service as a highly personalised service.

### Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998 and staff had signed confidentiality agreements.
- Although the reception area and waiting room were small, reception staff were aware of strategies to maintain and support patient privacy and confidentiality.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**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, advanced booking of appointments up to three months and advice services for common ailments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered however there were limited disabled facilities. The practice had a small car park however a designated disabled car parking space was not available. Access to the building was through two entrance doors. A patient on their own in a wheelchair would need assistance opening and passing through the two entrance doors however there was no bell for them to press to call for assistance.
- The practice made reasonable adjustments when patients found it hard to access services. For example, home visits were provided for housebound patients and telephone consultations for patients unable to access the practice within normal opening times.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in the setting they lived, whether it was at home or in a care home.
- The practice worked with Age UK North Staffordshire to provide the '80 PLUS' service, a social assessment for patients over 80 years of age. This included for example, support in applying for the attendance allowance, referral to befriending services to reduce social isolation and a falls risk assessment.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

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 had shared care arrangements in place with local hospitals to support patients with long term conditions such as rheumatoid arthritis.

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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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. For example, flexibility within the appointment system to accommodate appointments outside of routine hours.
- 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 such as those with a learning disability.
- The practice considered all of the patients living in a nearby care home as vulnerable. The GP carried out an annual review of their health.

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

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients with dementia were offered an annual health review.

### Timely access to the service

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.
- The appointment system was easy to use with on the day appointments available and prebookable appointments up to three months in advance.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly higher than local and national averages. This was supported by observations on the day of our inspection and completed comment cards. Two hundred and eight surveys were sent out and 124 were returned. This represented approximately 6.6% of the practice patient population. All of the 15 patients we spoke with on the day of our inspection told us there was great flexibility with access to appointments and the GP went the extra mile to ensure patients were seen promptly.

- 97% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 98% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 69% and the national average of 71%.
- 97% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 86% and the national average of 84%.
- 99% of patients who responded said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 98% of patients who responded described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 94% of patients who responded said they do not normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

### Listening and learning from concerns and complaints

The practice had a complaints policy in place. Information about how to make a complaint or raise concerns was available on the practice's website. There were readily available NHS leaflets for patients informing them who they could complain to outside of the practice. However, the practice's own complaints leaflet was not readily available for patients to access. We reviewed the practice's complaints leaflet and saw that it needed updating. For example, where patients could obtain help and advice and the person to contact within the practice.

The practice informed us they had received no complaints within the previous 12 months. We discussed this with the practice and found that a complaint had been received but it was being dealt with through other legal bodies. There were no records of the complaint within the practice and no evidence that the practice had followed their own internal procedures in dealing with the complaint.

# Are services well-led?

Requires improvement

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

## Our findings

**We rated the practice, and all of the population groups, as requires improvement for providing a well-led service.**

The practice was rated as requires improvement for well-led because:

- A strategy, or formal system of monitoring that priorities within the practice were achieved, was not in place.
- Systems to support compliance with the requirements of the duty of candour were not always followed.
- Overarching governance systems were not always effective.
- A formal system of monitoring, sharing and acting on Medicines and Healthcare products Regulatory Agency (MHRA) alerts was not in place. Some staff we spoke with within the practice were not aware of any alerts. Following our inspection, the GP told us that the practice manager had signed up to receive the alerts and they would be shared with other staff within the practice.
- Opportunities to assess, monitor and mitigate risks relating to safety were not always actioned. For example, receptionists who chaperoned but had not been subject to safeguarding checks.
- Systems to monitor standards and quality issues had identified issues but they had not been acted on.

### Leadership capacity and capability

The single-handed GP was the main leader within the practice and was supported by the practice manager. They were visible in the practice and staff told us that they were approachable and took the time to listen to all members of staff. They worked closely with staff and others to make sure they prioritised compassionate leadership. Although the leaders were clear about their role there was minimal delegation of duties or challenge to existing practices.

### Vision and strategy

The practice had a vision to provide patients with personal health care of a high quality and to seek continuous improvement on the health status of the practice population overall. They aimed to achieve this by being responsive to people's needs and expectations which reflected, whenever possible, the latest advances in Primary Health Care. Staff we spoke with were aware of the vision. However, supporting business plans to achieve priorities were not in place and there was no clear strategy how this would be achieved. A formal system of monitoring progress was not in place.

### Culture

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. Staff told us there was an open culture within the practice and they were able to raise any issues with the management team, felt confident in doing so and felt supported if they did.
- There were positive relationships between staff and the management.
- There were processes for providing staff with the development they needed. This included appraisal and all staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Systems to support compliance with the requirements of the duty of candour were not always followed. The practice informed us they had received no complaints within the previous 12 months however, we found that a complaint had been received but it was being dealt with through other legal bodies. There were no records of the complaint within the practice and no evidence that the practice had followed their own internal procedures in dealing with the complaint. Procedures to support patients to complain were not fully implemented. The practice informed us there had been no significant events in the previous 12 months.However, we saw that dispensing errors within the dispensary had been recorded as near misses and opportunities for analysis and learning from these events had been missed.
- The practice had not actively promoted equality and diversity. Staff had not received equality and diversity training and disabled access to the practice had not been fully considered.

### Governance arrangements

There were clear responsibilities and roles of accountability. However, structures, processes and systems to support good governance and management were not clearly set out or effective.

# Are services well-led?

Requires improvement

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

- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Staff had completed a dispensary audit that looked at the timeliness of the availability of prescriptions within 48 hours.
- There had not been a recent review of the governance arrangements and strategies and plans were not in place to monitor performance.
- Policies and procedures were in place but many of them were incorrectly dated 2018 or were undated with no evidence of review or updating to reflect current best practice guidelines.
- Staff recruitment checks did not meet legal requirements.
- Systems for updating protocols for the care of patients with diabetes or asthma to reflect current National Institute for Health and Care Excellence (NICE) guidelines had not been carried out. However, the GP had identified this as a need in their appraisal.
- The Quality Outcome Framework (QOF) results for 2016/17 showed that care and treatment provided for patients with long term conditions, such as asthma, high blood pressure or diabetes, and patients experiencing poor mental health were not effective.
- A proactive system for the identification of carers registered with the practice was not in place.
- Not all appropriate staff were aware of manufactures' temperature range guidelines in which medicines must be stored. Some staff were not aware of where emergency medicines were kept within the practice.
- We saw that the practice's standard operating procedure for the receiving of controlled medicines into the practice was not followed. Practices followed by staff regarding the management of controlled medicines left them exposed and vulnerable to scrutiny. We shared our findings with the Controlled Drugs Accountable Officer for North Staffordshire.

### Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- A limited number of risk assessments had been completed to assess and mitigate risks to patient safety. However, risk assessments to demonstrate how risks to patients would be mitigated for non-clinical staff had not been completed. For example, Disclosure and Barring Service (DBS) checks had not been undertaken for staff who chaperoned; staff who had not received immunisation against potential health care acquired infections.
- The practice had processes to manage current performance. Performance of clinical staff could be demonstrated through appraisal. Practice leaders had oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts and incidents, however there was no formal system of monitoring, sharing and acting on them.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice and improve quality although the improvements made were not always recorded within a second audit cycle.
- The practice had plans in place for major incidents and all staff had received fire training. A business continuity plan dated 2013 had been developed and several additions to the plan had been made over the past four years.

### Appropriate and accurate information

- The practice worked with the local clinical commissioning group (CCG) to monitor their performance through the quality information framework (QIF). Performance information was reported, monitored and there were plans to address some identified weaknesses. For example, the practice had reviewed their system of recall for patients with long term conditions and breast cancer screening.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- Quality was discussed in relevant meetings where staff had sufficient access to information.
- The practice used information technology systems to monitor and improve the quality of care. For example, text message reminders to patients and a system to manage investigation results.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

# Are services well-led?

Requires improvement

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

- Quality and operational information was used to improve performance. However, we saw that systems in place to monitor standards and quality issues had identified issues but they had not been acted on. For example, the training matrix showed that several members of staff had not completed mandatory training and some staff had not received training specific to their role. The system to monitor that cervical cytology results were received for all patients showed a result had not been received but this had not been followed up by the practice. Following our inspection the practice informed us the result had been received into the practice 16 days after the test had been completed but the spreadsheet had not been updated to reflect this.

### Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support sustainable services.

- Patients' and staff views and concerns were encouraged and acted on to shape services and culture. For example, a practice nurse told us that the leaders had listened to their request to increase appointment times of health reviews for patients with diabetes from 20 minutes to 30 minutes to ensure their needs were fully assessed.
- There was a virtual patient participation group (VPPG). We spoke with two patients from the VPPG who told us the GP kept them up to date with developments within the practice and listened to any concerns or suggestions they may have had.
- The GP engaged with 10 other practices in the locality for peer support and review.

### Continuous improvement and innovation

Patient feedback from the national GP survey, our Care Quality Commission comment cards, patients we spoke with on the day of our inspection and members of the VPPG were highly complementary of the service provided. Patients felt there were no changes required within the practice. We found limited evidence of continuous learning and improvement within the practice. However, the practice was involved in local projects to support frail, older patients and decrease A&E and unplanned hospital admissions.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:<br>• Reception staff who chaperoned had not be subject to Disclosure and Barring Service (DBS) checks. A risk assessment to mitigate potential risks to patients had not been completed.<br>• Not all members of staff were aware of where the emergency medicines were stored.<br>• Systems to monitor cervical screening results were received and acted upon were not effective.<br>• Action plans or action to mitigate risks identified in the fire and legionella risk assessments had not been completed.<br>• Opportunities to identify, analyse, learn and identify trends in significant events were not always taken.<br>• Processes to act on alerts were not always followed. An effective system was not in place for the sharing and acting on of MHRA alerts.<br>There was no proper and safe management of medicines. In particular:<br>• Practice standard operating procedures for the receiving of controlled medicines into the practice were not always followed.<br>• Not all staff who monitored the temperature of the medicine fridge were aware of the manufactures' temperature range guidelines. |

This section is primarily information for the provider

# Requirement notices

This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:<br>• Safety policies were undated or dated incorrectly meaning staff could not be sure they accessed the most recent policies for guidance and support. The policy for safeguarding vulnerable adults did not reflect updated categories or definitions of the types of abuse or outline who to go to for further guidance.<br>• A strategy, or formal system of monitoring that priorities within the practice were achieved, was not in place.<br>• Systems to support compliance with the requirements of the duty of candour were not always followed. Specifically reporting and analysing of significant events and complaints.<br>• Overarching governance systems were not always effective.<br>• Systems to monitor standards and quality issues had identified issues but they had not been acted on.<br>• Protocols for the care of patients with diabetes or asthma had not been updated to reflect current National Institute for Health and Care Excellence (NICE) guidelines. |

This section is primarily information for the provider

# Requirement notices

- The Quality Outcome Framework (QOF) results for 2016/17 showed that care and treatment provided for patients with long term conditions, such as asthma, high blood pressure or diabetes, and patients experiencing poor mental health were below local and national averages. Their exception reporting of patients with asthma or patients experiencing poor mental health was significantly higher than local and national averages.
- A system to monitor professional registrations were in date was not in place.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**How the regulation was not being met:**<br>The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate training as was necessary to enable them to carry out the duties they were employed to perform. In particular:<br>• Some staff had not received mandatory training as identified by the practice. For example, health and safety, equality and diversity, safeguarding children and vulnerable adults.<br>• Not all clinical staff involved in the assessment of the mental capacity of a patient had received training or updates specific to this role to support them in providing appropriate treatment for people who lack mental capacity. |

This section is primarily information for the provider

# Requirement notices

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.