Dr Anoop Sahal

Quality Report

94 Navigation Road
Altrincham
Cheshire
WA14 1LL
Tel: 0161 929 9300
Website: www.thefamilysurgeryaltrincham.nhs.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Anoop Sahal on 14th January 2015. Overall the practice is rated as good.

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

During our inspection the comments from patients were positive about the care and treatment they received. In the national GP survey 2014 99% of respondents describe their overall experience of this practice as good, 12% above the national average.

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned, with the exception of safeguarding and Mental Capacity Act training.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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

Importantly the provider must:

Summary of findings

Ensure the GP completed level three safeguarding (children) update and all staff completed safeguarding training for children or adults.

Ensure all clinical staff have undergone disclosure and barring (DBS) service checks.

In addition the provider should:

- Ensure full audits of practice are undertaken, including completed clinical audit cycles.
- Ensure all staff have appropriate policies, procedures and guidance in place for assessing patients under the Mental capacity Act 2005.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, staff had not completed safeguarding training and past recruitment practice had not included the required checks on criminal records via the disclosure and barring service. Information about safety was recorded and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is used routinely. People's needs are assessed and care is planned and delivered in line with current legislation.

Staff have received training appropriate to their roles, however we found that not all staff were clear of their roles and responsibilities in line with Mental Capacity Act 2005.

There were no fully completed audits of patient outcomes. We saw no evidence that audit was driving improvement in performance to improve patient outcomes.

The practice can identify appraisals and the personal development plans for staff. Multidisciplinary working was evidenced.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments

Summary of findings

available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice was responsive to the needs of older people, the GP and provided home visits and rapid access appointments for those with enhanced needs.

We saw care plans were in place for patients at risk of unplanned hospital admissions, and those aged 75 and over who were vulnerable had care plans in place.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Immunisation rates were high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. All of the staff were responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students).

Summary of findings

The practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice had extended opening hour enabling people to make appointments outside normal working hours. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

People whose circumstances may make them vulnerable

Good

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

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

The practice had sign-posted patients experiencing drug and or alcohol issues to support groups and voluntary organisations.

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

People experiencing poor mental health (including people with dementia)

Good

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

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

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

Summary of findings

What people who use the service say

During our inspection we spoke with six patients. We reviewed 28 CQC comment cards which patients had completed leading up to the inspection.

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

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 92% of respondents would recommend this surgery to someone new to the area and 91% said the last GP they saw or spoke to was good at treating them with care and concern.

Areas for improvement

Action the service MUST take to improve

We spoke with Dr Anoop Sahal who was the safeguarding lead, they had completed training to level three, but this was due to be updated in November 2014. We saw no other members of staff including the practice nurse had completed safeguarding training for children or adults.

We were satisfied that checks had been carried out with the disclosure and barring service (DBS) for Dr Anoop Sahal, however when recruited a number of years ago checks had not been carried out for the nurse. The practice manager told us they would ensure DBS checks where required would be carried out immediately following our inspection.

Action the service SHOULD take to improve

The practice showed us how they monitored patient data, but were unable to provide evidence of full clinical audits taking place which demonstrated changes to patient outcomes.

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

Dr Anoop Sahal

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Dr Anoop Sahal

Dr Anoop Sahal is a single handed GP practice which provides primary medical services in Altrincham from Monday to Friday. The practice is open between 8:30am and 6pm Monday to Friday; Dr Anoop Sahal offers appointments in the morning and afternoon, including an early morning surgery on Tuesday starting at 7am. The Nurse is available part time Tuesdays through to Friday. The practice provides home visits for people who were not well enough to attend the centre.

Dr Anoop Sahal is situated within the geographical area of NHS Trafford Clinical Commissioning Group (CCG).

Dr Anoop Sahal is responsible for providing care to 2037 patients of whom, 51% were male and 49 % were female. The practice had 6.21% of patients from black and minority ethnic groups.

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

Why we carried out this inspection

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

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

How we carried out this inspection

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

We carried out an announced visit on the 14th January 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

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

We reviewed 28 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

Detailed findings

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

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

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

Requires improvement

Are services safe?

Our findings

Safe Track Record

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

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

potential risk. All staff we spoke with knew to report concerns and incidents. We reviewed significant events which had been recorded and saw that appropriate action had been taken and where changes to practice were required; this had been discussed with staff.

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

The practice had systems in place to respond to safety alerts.

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

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

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice had in place arrangements for reporting significant incidents that occurred at the practice. We saw from the practice significant events records and speaking with staff investigations had been carried out and records of outcomes were available. All staff told us the practice was open and willing to learn when things went wrong. Staff told us learning from incidents was shared with the team and via email.

Staff told us they received updates relating to safety alerts they needed to be aware of via emails the nurse told us they received regular updates as part of their ongoing training, and self-directed learning.

Reliable safety systems and processes including safeguarding

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

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

We spoke with the GP who was the safeguarding lead, they had completed training to level three, but this was due to be updated in November 2014. We saw no other members of staff including the practice nurse had completed safeguarding training for children or adults.

A chaperone policy was in place, Speaking with staff who acted as chaperones, they were clear of the role and responsibilities. Training had been highlighted by the practice manager for all staff acting as chaperones and this was due to be completed in early 2015.

Medicines Management

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

Medicines administered by the nurses at the practice were given under a patient group direction (PGD), a directive

agreed by doctors and pharmacists which allows nurses to supply and/or administer prescription-only medicines. This had also been agreed with the local Clinical Commissioning Group.

The GP reviewed prescribing practices as and when medication alerts were received.

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

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or

following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

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

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

Cleanliness & Infection Control

The practice was found to be clean and tidy. The toilet facilities had posters promoting good hand hygiene displayed.

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

We saw staff had received infection control training; all staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities. Reception staff had access to gloves and alcohol gel if required when receiving samples from patients. We noted spillage kits were readily available behind reception.

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

We looked in the two consulting rooms; both rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. We saw the dignity curtains were disposable.

Equipment

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

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

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

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

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy in place. The practice had not recruited any new staff in over three years. We saw recruitment checks would include checks of the person's skills and experience through their application form, personal references, identification, criminal record and general health.

Where relevant, the practice also made checks that members of staff were registered with their professional

body, on the GP performer's list and had suitable liability insurance in place. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

We were satisfied that checks had been carried out with the disclosure and barring service (DBS) for Dr Anoop Sahal, however when recruited a number of years ago checks had not been carried out for the nurse. The practice manager told us they would ensure DBS checks where required would be carried out immediately following our inspection.

Monitoring Safety & Responding to Risk

As a single handed practice the accountability was with the GP, with the support of the practice manager. The GP was the lead for safeguarding, infection control and medicines management.

Staff spoken with and records seen confirmed that all staff had received training in medical emergencies including resuscitation techniques. All staff were trained to a minimum of basic life support.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. We saw where the GP was not available arrangements were in place with the local clinical commissioning group (CCG). Staff told us as they were such a small team, they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

There were plans in place to deal with emergencies that might interrupt the smooth running of the service. Within the business continuity plan there was clear guidance, with staff roles and responsibilities being clearly defined. A neighbouring practice had been identified as back up should it be required.

We saw fire safety checks were carried out.

Staff told us they had training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). In the event of an emergency staff would call emergency services. Staff were able to clearly describe to us how they would respond in an emergency situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff completed assessments of patients' needs and these were reviewed when appropriate. The GP described how he used 'Map of medicines' to ensure the care and treatment provided was in line with up to date guidance from NICE. Map of medicines provides and online pathway for clinicians to make appropriate decisions at the point of care and is validated by Royal College of General Practitioners.

Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails the nurse told us they received regular updates as part of their on going training, and self-directed learning.

Speaking with the practice nurse they explained to us how they reviewed patients with chronic diseases such as asthma and chronic obstructive pulmonary disease (COPD) on an annual basis. We saw from The National Quality Outcome Framework (QOF) patients with diabetes had received appropriate tests and treatment and those patients with atrial fibrillation were currently treated with anti-coagulation drug therapy or an antiplatelet therapy. We saw 100% of patients newly diagnosed with diabetes, had a record of being referred to an education programme to support them in managing their condition.

The practice maintained a register of patients with learning disability to help ensure they received the required health checks. Care plans were in place for those patients who were at high risk of unplanned hospital admissions.

The QOF provided evidence the practice were responding to the needs of people with dementia, including those newly diagnosed with dementia with 100% of patients receiving the appropriate tests. For patients with poor mental health data showed 94.4% of those diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the records.

We saw from QOF 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

Staff referred to Gillick competency when assessing young people's ability to understand or consent to treatment. Ensuring where necessary young people were able to give informed consent without parents' consent if they are under 16 years of age.

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

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or COPD. Assessments were carried out for patients with COPD and where required seasonal adjustments were made, which included prescriptions of medication to treat exhasabation in the home and prevent hospital admissions.

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

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

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

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma, diabetes and heart failure. They were also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 100% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Good

Are services effective?

(for example, treatment is effective)

Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement with 92.9% of outcomes achieved.

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

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support

Dr Anoop Sahal was up to date with their yearly continuing professional development requirements with revalidation planned for August 2015 (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list.

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

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

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

Working with colleagues and other services

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

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

For patients requiring support with alcohol or substance misuse the practice referred and worked closely with Phoenix futures a voluntary organisation that specialised in supporting people with drug and alcohol problems.

Information Sharing

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

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

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

Consent to care and treatment

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

There were no policies or procedure in place for staff to refer with regard to the Mental capacity Act 2005 and staff had not completed any training. Speaking with clinical staff they had an understanding of the principles of gaining consent but were not able to identify clearly their roles and responsibilities in line with the Mental Capacity Act 2005 and were unable to describe how they implemented it in their practice. Speaking with Dr Anoop Sahal, he was able to describe the use of the Mental Capacity Act 2005 when authorising Do Not Attempt CPR (DNACPR) and told us he would attend best interesting meetings where required.

Good

Are services effective?

(for example, treatment is effective)

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

Health Promotion & Prevention

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

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

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

The nurse provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. The nurse provided an in-house smoking cessation service.

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

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

We spoke with six patients and reviewed 28 CQC comment cards received the week leading up to our inspection. All but one were positive about the level of respect they received and dignity offered during consultations.

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

We saw all phone calls from and to patients were carried out in a private area behind reception we were told this helped to maintain patient confidentiality.

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

Looking at the results from the GP Patient Survey 2013, 96% of respondents found the receptionists at this surgery helpful.

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

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

Care planning and involvement in decisions about care and treatment

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

Patients we spoke with told us the GP and the nurse were patient, listened and took time to explain their condition and treatment options. This was reflective of the results from the National GP Patient Survey in which 99% of respondents describe their overall experience of this practice as good, 12% above the national average.

We saw from The Quality and Outcomes framework (QOF) data for 2012/13, 94.4% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.

Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions.

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

Patient/carer support to cope emotionally with care and treatment

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

From the National GP survey 96% of respondents stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern, 10% above the national average and 91% stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care again 10% higher than the national average.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an understanding of their patient population, and responded to meet people's needs.

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

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

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

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

The practice did not have a Patient Participation Group (PPG).

Tackling inequity and promoting equality

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

The practice was on one level and was accessible for patients with disabilities and had disabled parking spaces available. A disabled toilet was available as were baby changing facilities.

The practice provided extended appointments where necessary and appointments were available from 7am on a Tuesday to enabling people to make appointments out of normal working hours.

Access to the service

Patients were able to make appointments in advance, in person at reception, over the telephone or online on the day emergency appointments were available by telephoning the practice. Where all appointments were filled, reception staff would take patients details which would be followed up by the GP and where required same day appointments or telephone consultations would be arranged.

For vulnerable patients an alert system was in place to ensure whatever time of day they phoned, if required a same day appointment should be provided. We were told all children under five would be seen on the day.

The majority of patients were satisfied with the appointment system. We saw from the National GP survey 99% of respondents said the last appointment they got was convenient and 99% of respondents described their experience of making an appointment as good.

Home visits were available for patients each day by telephoning the practice before 10am.

Patients were guided to out of hours service with information provided on the website and answerphone should patients call the practice out of hours.

Listening and learning from concerns & complaints

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

We saw there was a complaints procedure in place. We reviewed complaints made to the practice over the past twelve months and found they were investigated with actions and documented and learning shared with relevant staff.

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

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

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice was a single handed GP service that was led by Dr Anoop Sahal supported by a nurse, a practice manager, administrator and reception staff. The practice described themselves as a family practice, we saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

The practice vision was to deliver high quality care and promote good outcomes for patients. Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality.

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

Governance Arrangements

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

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

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

The practice had informal processes in place to monitor quality and systems to identify where action should be taken, these were shared informally with staff, however the learning and outcomes were not routinely recorded.

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

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made.

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

The practice was a single handed GP service that was led by Dr Anoop Sahal and supported by a nurse, practice manager and reception staff. The GP was the lead for the practice and took the lead role

for safeguarding and infection control and governance. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all described to us an open and supportive work environment. Staff told us they would have no hesitation in speaking with the practice manager or the GP if anything was troubling them as they knew they would be supported, and where appropriate, action would be taken.

We saw from minutes that team meetings were held and daily informal communication took place daily between to the GP and practice manager. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings, or with colleagues as and when required. Staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

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

Are services well-led?

Good

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

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

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

The practice had gathered feedback from patients through the National Patient Survey, suggestion box, compliments and complaints.

The practice did not have in place a patient participation group (PPG) and did not have plans to establish a PPG, We were told the systems they had in place provided sufficient opportunities for patients to give comments and feedback.

We saw that there was a comprehensive complaints procedure in place, with details available for patients in the practice leaflet and on the website. We reviewed complaints made and found they were fully investigated with actions and outcomes documented.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 99% describe their overall experience of the practice as good.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning & improvement

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

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Dr Anoop Sahal who was the safeguarding lead, had completed training to level three, but this was due to be updated in November 2014. We saw no other members of staff including the practice nurse had completed safeguarding training for children or adults. DBS checks had not been carried out for the practice nurse.