Dr Ravi Latthe

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Ravi Latthe's practice on 28 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. We found that the practice was good for providing services to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

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

- There were reliable systems in place for the safe storage and use of medicines and vaccines within the practice.
- Staff had received training appropriate to their roles. Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and involved in decisions about their treatment.
- Information about services and how to complain was available for patients and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and urgent appointments available the same day.
- The practice had an open culture and staff felt supported and listened to.

There were also a number of areas of practice where the provider should make improvement. Importantly the provider should:

- Ensure that receptionists are clear about their responsibilities when acting as chaperones, particularly in relation to where to stand when intimate examinations take place.
- Ensure that all policies and procedures in place to govern activity are reviewed in a timely manner and updated as appropriate.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Lessons were learned and communicated widely to support improvement. The practice had arrangements for identifying, recording and managing risks. There were reliable systems in place for safe storage and use of medicines and vaccines within the practice. Staff recruitment systems were robust. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand. We saw that there had not been any complaints made to the practice in the last year. Patients we spoke with said that they had not needed to make a complaint at all.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about their responsibilities in relation to providing a good standard of care for patients. Staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality. The practice proactively sought feedback from staff and patients, which it acted on. The practice carried out an annual satisfaction survey for patients and was in the process of setting up a patient participation group (PPG) at the time of the inspection.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had the lead role in chronic disease management. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of harm. Immunisation rates were above average for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We saw evidence to confirm this. Appointments were available outside of school hours.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Practice staff had identified patients with learning disabilities and treated them appropriately. All patients within this group had received annual health checks. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients who experienced poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health such as the community psychiatric nurse. It also carried out advance care planning for patients with dementia.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) including those that may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We reviewed 45 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that all comments recorded were positive, however two completed cards included comments from patients who felt that some locum GPs used by the practice did not communicate with them. Patients commented that they received an excellent service by everyone at the practice and that staff were helpful, respectful and listened to them. Patients also commented that they could always see a GP when they needed to.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated January 2015 and a survey of patients undertaken by the practice during June 2014. The evidence from these sources showed that patients were satisfied with the service they received and felt that they were given enough time and treated with care and compassion.

The practice was above average for its satisfaction scores on consultations with GPs and nurses. Data showed that 97% were satisfied with appointment times which was comparable with the local Clinical Commissioning Group (CCG) average of 92%; 84% described their experience of making an appointment as good compared with the local CCG average of 74%; 90% would recommend this practice to someone new to the area which compared with a national average of 75%.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that receptionists are clear about their responsibilities when acting as chaperones, particularly in relation to where to stand when intimate examinations take place.
- Ensure that all policies and procedures in place to govern activity are reviewed in a timely manner and updated as appropriate.

Dr Ravi Latthe

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Dr Ravi Latthe

Dr Ravi Latthe's practice is known locally as Walsall Wood Health Centre and is located in Walsall in the West Midlands. The practice has two GPs both male, a practice manager, a practice nurse and administrative and reception staff. There were 1896 patients registered with the practice at the time of the inspection.

The practice is open from 9am to 6.30pm Monday to Friday. In addition to the extended hours service each day, the practice provides appointments until 7.30pm once per month when needed. The practice is closed at weekends. Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions, book appointments and update personal details.

The practice provides extended hours for those patients who have working commitments. Each day the practice offers appointments up to 6.30pm. During these extended hours the GPs do not have access to the support services that are usually available during normal working hours, such as practice nurses, however administrative staff do offer support at that time.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics which includes asthma, diabetes and heart disease.

The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed via the Walsall Doctors on Call service.

Dr Ravi Latthe's practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The practice had previously been inspected on 18 July 2013 and 16 June 2014 and we found that action was needed to meet the standards required in relation to infection prevention and control systems. During this inspection, we checked to see if these standards had been met.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Before our inspection of Dr Ravi Latthe's practice we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted NHS Walsall Clinical Commissioning Group (CCG) and NHS England area team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 28 April 2015. During our inspection we spoke with a range of staff that included two GPs, the practice manager, nursing and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with six patients who visited the practice during the inspection. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. These records showed the practice had managed these consistently over time and could show evidence of a safe track record over the year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these.

We saw that significant events were discussed regularly at practice meetings and was a standing item on the practice meeting agenda. Effective action plans were put in place when required. The lead GP confirmed that a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. We also saw evidence that the actions identified for learning or improvement, as a result of individual significant events, had been completed. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. GPs we spoke with confirmed this. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw that national patient safety alerts were taken seriously and acted upon by the clinicians in the practice. However, there was not a standardised process to ensure that each clinician responded to the alert in a consistent way. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings when appropriate to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible for staff in the reception area and offices.

Both GPs were the dedicated leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, we saw that all clinical staff at the practice had completed safeguarding for children training to an advanced level in 2014. We also saw that both GPs and the practice nurse were booked to attend a serious case review and safeguarding event in April and June 2015. All staff we spoke with were aware who the leads were and who to speak to within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example vulnerable patients or children who may be at risk of harm. GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The GPs were aware of vulnerable children and adults and records demonstrated good liaison with partners such as health visitors.

There was a chaperone information notice which was visible on the waiting room wall. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We saw that the practice nurse had been

trained as a chaperone. Reception staff would act as a chaperone if the practice nurse was not available. We saw that receptionists had received criminal record checks through the Disclosure and Barring Service (DBS) and had also undertaken training in relation to chaperone duties. We found that they understood their responsibilities when acting as chaperones, however they were not clear about where to stand when intimate examinations took place.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed that the practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of every three months and in line with waste regulations.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the practice nurse had received appropriate training to administer vaccines. We saw that the practice nurse received regular support in their role as well as training updates in their specific clinical areas of expertise.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Staff told us that when a prescription was ordered by patients who used high risk medicines, staff checked that the required blood tests had been completed and took appropriate action based on the results.

We saw that the practice had a prescribing policy. Staff were clear that all prescriptions should be reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

During this inspection, we observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Feedback in the patients' comments cards was also consistent with this and they also found the practice to be clean and hygienic.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

We saw evidence that the Walsall Healthcare NHS Trust had carried out an infection prevention and control audit of the practice on 9 March 2015. We saw that the practice had achieved a score of 92% for this audit and an action plan had been developed to address areas for improvement.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

At our previous inspections the provider could not demonstrate that the privacy curtains in the treatment rooms were regularly cleaned. At this inspection we saw that the privacy curtains had been exchanged for a disposable type and had been changed again in March 2014.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

At the previous inspection in June 2014, we were told that there had been a flood in the surgery the week prior to the inspection. We saw that flooring had been removed in the waiting area which meant it would be difficult to keep clean. We saw that there were areas of dampness in the

entrance hall and in the disabled toilet. We also saw that the skirting board in the entrance hall was damaged and wallpaper had come away in the waiting area. Some chairs in the treatment rooms were seen to be made of a permeable material and also difficult to keep clean. During this inspection we saw that the flooring had been replaced in the waiting area and no areas of dampness were found in the entrance hall or toilet. We saw that the skirting board in the entrance hall had not been changed. The chairs in the treatment rooms had been replaced and were now made of a permeable material to enable them to be kept clean.

The practice manager informed us that a bid to upgrade the building was in the process of being put together to submit to the Clinical Commissioning Group. This refurbishment plan included a proposal to change the entrance to the practice.

Equipment

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

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice did not have arrangements for identifying, recording and managing risks at the time of the inspection. However the practice took immediate action and following the inspection we received a variety of documents which demonstrated that the practice had developed processes to manage and monitor risks to patients, staff and visitors to the practice. These were seen to include fire and evacuation processes including fire drills and processes to deal with emergencies.

The GPs and practice manager told us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and contact was made to follow up on patients where they failed to attend.

Arrangements to deal with emergencies and major incidents

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

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

A continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and actions recorded to manage the risk. Risks identified included loss

Good

Are services safe?

of computer system and loss of power. The document was seen to contain relevant contact details for staff to refer to. For example, contact details of an electrical company to contact if the power system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The practice nurse was responsible for the management of all chronic disease reviews in the practice such as diabetes, heart disease and asthma. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, management of child protection alerts and medicines management.

The practice showed us two clinical audits that had been undertaken in the last 12 months. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through a systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards are being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met. We saw that one of the audits completed was an audit of patients who used a high risk medicine. A follow up audit had been carried out at a later date which showed that the action taken by the practice demonstrated positive changes for patients since the initial audit. This included targeting those patients who did not turn up for regular blood tests and increasing the number of patients who attended the practice for their regular reviews.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Following the audits, the GPs shared their findings with relevant staff and looked at ways to make improvements where these had been identified. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In most areas the practice had reached performance levels that were higher than the national average. For example, the number of patients with diabetes who had received their flu injection was 96% which compared with the national average of 93%.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe this outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

The practice had implemented the gold standards framework (GSF) for end of life care. It had a palliative care register and had regular internal as well as quarterly multidisciplinary meetings to discuss the care and support needs of patients and their families. One of the receptionists at the practice was the GSF co-ordinator for the practice and attended these meetings. As a consequence of this staff had a greater awareness of the needs of the patients on the register. The practice had introduced a GSF 'watch list' which we saw was a proactive approach to closely managing patients on the register.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed that the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support. Both GPs were up to date with their yearly continuing professional development requirements and both had been revalidated, one GP in June 2014 and the other GP in February 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The GPs and practice nurse performed clearly defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology for the practice nurse. Records also showed that one of the GPs and the practice nurse had received appropriate training in managing patients with long term conditions such as asthma and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for responding to hospital communications was working well in this respect.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example those with end of life care needs or children on protection plans. These meetings were attended by district nurses, health visitors, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had a system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals although not all referrals were made by the practice through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found from discussions with staff that they had not all received training on the Mental Capacity Act 2005. The clinicians we spoke with were aware of the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical

Good

Are services effective?

(for example, treatment is effective)

staff we spoke with understood the key parts of this legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making 'do not attempt resuscitation' orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic medicine reviews.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering additional help**.** For example, the practice kept a register of all patients with a learning disability and ensured that they were offered longer appointments for an annual physical health check.

The practice's performance for cervical smear uptake was high at 91.8% which was better than the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. There was also an alert for this on the individual patient records. The practice nurse was responsible for following up patients who did not attend screening appointments.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations carried out by the practice was above average for the CCG and again there was a clear policy for following up non-attenders by the practice nurse.

We saw that a range of health promotion leaflets were available in the reception area. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given lifestyle link cards which provided information to access services and information they needed.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015 and the results of a patient satisfaction survey completed by the practice in June 2014. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good (95%). The practice was also well above the local Clinical Commissioning Group (CCG) and national average for its satisfaction scores on consultations with GPs and nurses with 93% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and almost all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments contained both positive (about the service provided by the practice) and negative feedback, (some locum GPs used at the practice did not communicate with them). We also spoke with six patients on the day of our inspection. All told us that they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that there was a TV screen used for healthcare advertising which was located near the practice reception desk. This helped to reduce the possibility of patients overhearing potentially private conversations between other patients and reception staff. We saw this system in operation during our inspection and noted that it supported patient confidentiality to be maintained.

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

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. We saw that patients generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 91% felt the GP was good at explaining treatment and results. Both these results were above average when compared with the local CCG area. The results from the practice's own satisfaction survey showed that the practice endeavoured to engage patients in their care. We saw that the practice had taken steps to provide printed information regarding certain conditions for patients to read at their leisure. The GPs felt this reinforced the consultation and positive results had already been noted in relation to this.

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

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

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Feedback from patients showed that they were positive about the emotional support provided by the practice. For example, one patient wrote in the comment cards that they had received significant support from the practice when they had a recent bereavement. They told us that staff were caring, kind and supportive. Comments from other patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this feedback. Patients told us that staff were always ready to provide help and support when they needed it.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers in the practice which helped them to understand the various avenues of support available to them.

Staff told us that if families had suffered a bereavement their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service via the community services. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

Staff told us that the practice had a range of patients across all age groups. National patient data showed that the number of patients in the over 65 years of age population group at the practice was approximately 18% compared with the national average of 16.7%. The population group of patients over 75 years of age at the practice was 6.5% compared with the national average of 7.6% and patients under the age of 18 years at the practice was 14.1% compared to the national average of 14.8%.

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

The practice provided a range of services to meet the needs of their patient population. For example, the practice had a palliative care register and we saw that regular multidisciplinary team meetings (MDTs) took place to support patients with palliative care needs and their families. We saw that patients with a long term condition such as asthma or diabetes were monitored and regularly checked at the practice. Staff told us that they offered support to these patients on how to manage their condition and gave them advice on healthy eating and smoking cessation.

Staff told us that patients who experienced poor mental health were signposted to a variety of support groups and voluntary organisations. This included a counselling group who provided a counselling service for young people who would be seen without having to have an adult present.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and the practice had access to online and telephone translation services for those patients who did not have English as their first language.

There were arrangements in place to ensure that care and treatment was provided for patients with mobility problems. The practice was situated on the ground and first floor of the building with all services for patients on the ground floor. We saw that patients with wheelchairs and prams had enough room to move around the practice with access to the treatment and consulting rooms. The practice manager told us that there were plans to refurbish the building to make it more accessible. We did not see the plans for the refurbishment.

Staff at the practice told us that they had not received equality and diversity training. The practice manager confirmed that this would be useful. However, staff we spoke with were knowledgeable and concerned about promoting equality and recognised the diverse needs of patients and the most appropriate way to meet those needs for patients. The practice manager confirmed that efforts were being made to secure a female GP to work at the practice to enable patients to have a choice of GP.

Access to the service

The practice was open from 9am to 6.30pm Monday to Friday. In addition to the extended hours service each day, the practice provided appointments until 7.30pm once per month if needed.

Comprehensive information was available to patients about appointments in the practice information leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients needed advice from a GP when the practice was closed, an answerphone message gave the telephone number they should ring for the out-of-hours service. This information was also provided to patients in the practice information leaflet.

Longer appointments were also available for patients who needed them, for example patients with a learning disability and those with long-term conditions. The GPs at the practice carried out visits to a local care home on request for their patients who needed a home visit. We saw that for those patients who were housebound the nurse offered them flu injections at home.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how recently they had needed an urgent appointment and were seen by a GP on the same day.

The practice's extended opening hours were particularly useful to patients with work commitments. This was confirmed by three patients we spoke with on the day of the inspection.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system with details on how to make a complaint on the practice website, in the practice information leaflet and in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We found that the practice had not received any complaints in the last 12 months, however we saw that there had been an annual review meeting of the complaints process held in February 2015. Minutes seen from this meeting showed that staff were committed to ensuring patients received the care they required and any future complaints would be handled promptly and appropriate action taken.

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 manager told us that the vision was to deliver high quality care and promote good outcomes for patients. They informed us that it was intended that the practice building would be extended subject to various approvals from the Clinical Commissioning Group and Local Authority to enable patients to have an improved experience when visiting the practice. At the time of the inspection a bid was being put together by the practice and if successful, would facilitate an improved environment for patients.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us that they felt they were an integral part of the team and were actively encouraged to make suggestions for making further improvements. The practice manager told us they were continually striving to improve the service for patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and saw that they needed to be updated. Staff told us that they were in the middle of changing IT systems and this was partly the reason for this.

We did not see a clear leadership structure with named members of staff in lead roles. The practice manager told us that this needed to be done. However, we spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed performance was generally above national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. The practice nurse told us they took part in educational practice nurse groups with the CCG lead, which was a local peer review system for practice nurses.

The practice did not have arrangements for identifying, recording and managing risks at the time of the inspection. However the practice took immediate action and following the inspection we received a variety of documents which demonstrated that the practice had developed processes to manage and monitor risks to patients, staff and visitors to the practice. These were seen to include fire and evacuation processes including fire drills and processes to deal with emergencies.

Leadership, openness and transparency

We saw from recorded minutes that team meetings were held, however these were infrequent. We saw that the practice had had four practice meetings in the last year. Staff told us that they met regularly to discuss key issues but these were not always recorded. Staff told us that there was an open culture within the practice and that they had the opportunity and were happy to raise issues at team meetings or at other times.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example an induction policy, and the equal opportunities and anti-discrimination (employment) policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and saw that the main points for the practice to action included: to continue to improve patient access by telephone and for GPs to continue to ensure that patients', their families and carers were fully engaged in care and decisions about their treatment options. Comment card feedback and patients we spoke with showed that these actions were highly regarded by patients.

We saw that the practice was in the process of setting up a virtual patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG is to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients. It was envisaged that the PPG would include representatives from various population groups including patients of working age, retired patients and young patients. A virtual PPG is one that does not necessarily have to meet in person but can contribute via the internet and email suggestions and respond to any

Are services well-led?

Good

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

service development proposals made by the practice. The practice manager showed us the analysis of the last patient survey. The practice manager confirmed that results and actions agreed from the annual surveys would be made available to patients on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. One member of staff told us it was the best place they had ever worked.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They said that the practice was very supportive with training. We looked at five staff files and saw that regular appraisals took place which included identified training needs.

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