Dr Nityananda Hati-Kakoty

Quality Report

Bee Fold Medical Centre
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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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Dr Nityananda Hati-Kakoty on 21 November 2014. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We assessed all six of the population groups and the inspection took place at the same time as we inspect a number of practices in the area overseen by Wigan and Leigh Clinical Commissioning Group (CCG).

The overall rating for Dr Nityananda Hati-Kakoty was good.

Our key findings were as follows:

- Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our visit. A system was in place for managing infection prevention and control.
- The practice had systems in place to ensure best clinical practice was followed. This was to ensure that people's care, treatment and support achieved good outcomes and was based on the best available evidence.
- Information we received from patients reflected that practice staff interacted with them in a positive and empathetic way. They told us that they were treated with respect and always in a polite manner.
- A care plan was in place for patients who had a high risk of an unplanned hospital admission. These were managed and updated by the practice nurse who regularly visited patients at risk to assess any changes and ensure they were involved in their plan of care.
- Patients spoke positively in respect of accessing services at the practice. Open surgeries were held for patients to access the GP on the day of their choice, and appointments could be made to see the practice nurse.

Summary of findings

- There was a very small staff team and a single handed GP. They all worked closely together as a team, there was very little staff turnover or sickness, and all staff felt well supported and work with training being provided appropriately.

We found areas of outstanding practice:

- The practice operated an open surgery system for accessing GP consultations. This meant that patients could attend during the surgery session of their choice and they were guaranteed a consultation with the GP.
- Appointment times were not fixed so patients were seen for as long as was required. This meant that where more explanation and discussion was needed the GP or practice nurse was able to do this. Patients highlighted this as a positive part of the practice; they did not feel rushed and felt they were fully informed with all aspects of their care.
- Prior to any longer holiday weekends the GP spoke with patients who had been identified as having a particularly high risk of an unplanned hospital admission. This was to ask if there was anything they required.

There is an area where the provider must make improvements:

- The dignity, privacy and independence of young people under 16 who have the legal capacity to consent must be ensured, and these young people must be treated with consideration and respect.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Requires improvement

The practice is rated as requires improvement 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. Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

The practice nurse would not see patients under the age of 16 to give them advice about contraception. They said they would ask them to return with a parent. The GP told us they would see patients under the age of 16 but they would have a chaperone present.

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

The practice did not routinely see patients under the age of 16 unless they attended with a parent. Young people were therefore not treated in a dignified way and were not able to be involved in decisions about their care and treatment.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice knew the individual needs of their patients and were able to recognise when further interactions were required. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients reported excellent access to GP appointment, always on the day they preferred. The results of national and practice patient surveys provided evidence of patients' satisfaction with the system, with the results being higher than the CCG average. No appointment was necessary and the GP held open surgeries. Although there was no late night opening the GP was flexible and would stay later when they knew a patient needed to be seen. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. Staff were clear about their roles and responsibilities. There was a clear leadership from the GP and practice manager and staff felt supported at work. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place, both informally and formally. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. Staff had regular performance reviews, regularly attended staff meetings, and there was an induction programme in place for new staff.

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. The practice nurse knew patients well and called to see them in their homes to update care plans and ensure they felt involved in their care. We saw examples of the nurse identifying changes to patients' health during these reviews and arranging further treatment.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The GP knew the patients well and was able to identify when there were changes to a patient's condition. Referrals to other services were made as required. All these patients had a structured review at least once a year to check their health and medication needs were being met. We saw examples of the GP proactively making contact with patients who had a higher risk of hospital admission to check on their condition and ensure they had sufficient medicines prior to holiday weekend, with a view of reducing the need for out of hours service interaction or hospital admission.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Parents who were concerned about the health of their children were able to access a consultation on the day of their choice.

Although the GP and practice nurse told us they were aware of the Gillick Competencies there were no formal procedures to follow. The practice nurse would not see a patient under the age of 16 without a parent being present and the GP said they would, but only with a chaperone. This did not ensure young people were treated in an age appropriate way and recognised as individuals.

Working age people (including those recently retired and students)

Good

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

Summary of findings

students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice did not open later than 6.30pm but any patient who worked could attend the practice before this time and be seen. Patients between the ages of 40 and 70 were invited for a health check.

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 held a register for patients with learning disabilities. They did not have any homeless people or travellers registered with them. Patients with learning disabilities were invited for an annual health check. The practice offered consultations that were need specific, so more time could be given to patients when required.

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

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place care planning for patients including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary. Patients could be referred for counselling.

Summary of findings

What people who use the service say

We received 21 completed CQC patient comment cards and spoke with five patients at the time of our inspection visit. We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed our comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They also told us that they were treated with respect and that their privacy and dignity was maintained. In particular they highlighted the convenience of the open surgery system, where they could access an appointment on the day of their choice.

We also looked at the results of the 2014 national GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results showed;

95% of respondents describe their experience making an appointment as good. The Clinical Commissioning Group (CCG) average was 78%.

92% of respondents said they would recommend the practice to someone new to the area. The CCG average was 81%.

100% of respondents said the appointment they had was convenient. The CCG average was 94%.

100% had confidence and trust in the last GP they saw or spoke to. The CCG average was 93%.

Areas for improvement

Action the service MUST take to improve

- The dignity, privacy and independence of young people under 16 who have the legal capacity to consent must be ensured, and these young people must be treated with consideration and respect.

Outstanding practice

- The practice operated an open surgery system for accessing GP consultations. This meant that patients could attend during the surgery session of their choice and they were guaranteed a consultation with the GP.
- Appointment times were not fixed so patients were seen for as long as was required. This meant that where more explanation and discussion was needed the GP or practice nurse was able to do this. Patients highlighted this as a positive part of the practice; they did not feel rushed and felt they were fully informed with all aspects of their care.
- Prior to any longer holiday weekends the GP spoke with patients who had been identified as having a particularly high risk of an unplanned hospital admission. This was to ask if there was anything they required.

Dr Nityananda Hati-Kakoty

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC lead inspector, a GP specialist advisor and a practice nurse specialist advisor. Our inspection team also included an Expert by Experience who is a person who uses services themselves and wants to help CQC to find out more about people's experience of the care they receive.

Background to Dr Nityananda Hati-Kakoty

Dr Nityananda Hati-Kakoty is located in Bee Fold Medical Centre in the Atherton area of Manchester. It is a single-handed GP practice and at the time of our inspection 1985 patients were registered.

The practice team consisted of one GP, a practice nurse, practice manager and administrative and reception staff.

The practice delivers commissioned services under a Primary Medical Services (PMS) contract.

Dr Nityananda Hati-Kakoty had opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider.

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 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

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

The working-age population and those recently retired (including students)

People in vulnerable circumstances who may have poor access to primary care

People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 21 November 2014. We reviewed all areas that the practice

Detailed findings

operated, including the administrative areas. We received 21 completed patient comment cards and spoke with five patients during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with the GP, the practice nurse, the practice manager and members of the reception team.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included national patient safety alerts, comments made by patients and reported incidents. We saw that where safety incidents were identified at the practice the GP was notified. They were then investigated and managed, although the GP did not keep a formal record of incidents that had been identified by staff.

Before our inspection we reviewed a range of information we held about the practice and asked other organisations such as NHS England and Wigan Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

We saw evidence that significant events were escalated to the appropriate body, such as NHS England or the CCG. The staff we spoke with were all aware of how to report significant events. They told us that significant events, including the investigation, outcome and learning points, were discussed at practice meetings.

Learning and improvement from safety incidents

The practice had a system in place for managing safety alerts received from external agencies. The GP received the alerts directly. These were circulated to staff both electronically and by paper copy depending on the preferences of each staff member. Staff confirmed they received updates via the practice manager. We saw an example of where changes to practice had been made following an alert.

The practice had an informal system in place for reporting, recording and monitoring significant events, incidents and accidents. The GP managed this and we saw that events had been reported and monitored as required. We saw that significant event analysis (SEA) was carried out on all new cancer diagnoses. Records were kept on what had happened, what had been learned, and what practice had been changed, if any. An example of a change to practice following a delayed cancer diagnosis was seen. The practice nurse was not involved in SEA but was aware of what should be brought to the attention of the GP. There was evidence that the practice had learned from significant events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Most staff were aware of how to submit incident forms it was normal procedure for them to alert the practice manager or GP, who would complete the necessary documentation. The practice manager monitored any incidents and kept the relevant people informed of any updates or outcomes. The staff we spoke with told us there was an open culture and they were encouraged to report incidents or mistakes. They said they received support to do this, and all staff were aware of the procedure to follow.

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 saw that training was updated annually and the next training session had been booked. The GP had overall responsibility for safeguarding.

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. The safeguarding policy was accessible to all staff. We saw the policy contained guidance about safeguarding issues, procedures for reporting concerns, and the contact numbers of relevant agencies.

Patient appointments were conducted in the privacy of individual consulting rooms. The patients we spoke with told us they had never had reason to be offered a chaperone. However we saw there was a chaperone policy in place and staff had received training in their role if they were required to act as a chaperone. The policy did not give full instructions to staff, for example where they should stand while an intimate examination was taking place. It did state that a patient's records should be noted when a chaperone had been offered and then accepted or refused, but it did not state who should make the note.

Good

Are services safe?

Medicines management

We checked the medicines stored in the treatment rooms and medicine fridge. These included vaccines that needed to be stored within a specific temperature range. All medicines were securely stored and all within their expiry date. Appropriate medicines were held for use in an emergency. The temperature of the medicines fridge was monitored on a daily basis by the practice nurse, but other staff were also aware of the required procedure. A record was kept of these checks. Staff knew what action to take if the temperature was outside the required range. We saw that the practice nurse was responsible for the rotation of stock within the fridge to ensure medicines were kept in date, and we saw that in addition a monthly check of medicines was completed and recorded

There were systems in place for the management, secure storage and prescribing of medicines within the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions.

The GP showed us the bag they took with them on home visits. Appropriate medicines were carried and we saw there was a procedure in place to check the amount of medicines held and make sure they were within their expiry date.

Cleanliness and infection control

During our inspection we found the practice to be visibly clean and uncluttered. Systems were in place for ensuring the practice was regularly cleaned. A cleaner was employed by the practice. They attended the practice each afternoon when staff were still on the premises and could give them access to the required parts of the building. They spent longer on the premises once a week when the practice closed at lunchtime. We saw the practice had spillage kits they could use themselves. There was a cleaning schedule in place covering all aspects of cleaning the practice. The practice manager monitored this to ensure cleaning was carried out to the required standard.

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 were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely.

The practice nurse was the lead for infection control at the practice. The GP had attended an in-depth CCG infection control training course in June 2014, and this information had been disseminated to staff. On-line training had also been provided. We also saw evidence that guidance had been provided during practice meetings. We saw that appropriate hand washing facilities, including liquid soap and disposable towels, and hand washing instructions were available throughout the practice.

Audits had been carried out to ensure actions taken to prevent the spread of potential infections were maintained. We saw that where areas for improvement had been identified prompt action had been taken.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out checks to reduce the risk of infection to staff and patients.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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 weighing scales and the fridge thermometer.

Staffing and recruitment

We saw that the staffing team was well-established, with the most recently recruited staff member starting work eight years ago. 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

Good

Are services safe?

Disclosure and Barring Service (DBS). The practice was in the process of renewing DBS checks to make sure they were up to date. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice manager had a system in place so that staff were able to cover each other when they had holidays or unexpected absences. The staff we spoke with told us they supported each other and worked flexibly to meet the needs of the practice. The practice had an arrangement with another practice in the area so the GP from each practice could provide cover or additional sessions to the other practice if needed in an emergency. Locum GPs were also employed when required, and appropriate checks were carried out prior to them working at the practice.

Staff and patients 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

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that all staff received annual basic life support training. We looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

Health and safety training had been carried out previously and an updated training session had been booked for January 2015. The practice manager carried out regular checks on all aspects of the practice, both inside and outside the building. Not all these were documented but we saw evidence that where issues were identified repairs were made or changes put in place to reduce risk.

We saw the minutes from staff meetings that showed the safety of staff and patients was discussed during meetings. Information about health and safety, including fire safety, was disseminated during meetings.

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. 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 and all staff knew of their location. 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 business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that patients' care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), guidance published by professional and expert bodies, and within national health strategies were used to inform best practice at the practice. We saw that such standards and guidelines were easily accessed electronically by the GP. They then disseminated the information to other staff within the practice. Staff conformed they received regular updates at their practice meetings.

We saw the practice used computerised tools to identify patients with complex needs. When these needs had been identified we saw pathways were put in place to ensure the patients received the most effective care and treatment available. The practice manager showed us how they coded patients with different conditions. They told us the Clinical Commissioning Group (CCG) was very supportive and they were able to ask for advice if they were unsure of any coding issues. The practice manager attended annual training to keep up to date with the coding of conditions.

The GP had a system in place to check records completed by locum GPs used for periods of annual leave. We saw the GP used a computerised tool to prompt medicine interactions. This demonstrated their commitment to safe and appropriate prescribing.

The results of the 2014 nation GP patient survey showed that 100% respondents had confidence and trust in the GP.

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Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. There were quality improvement processes in place to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with the CCG. We saw evidence of the clinical audits cycles that had been carried out. These included the identification of patients with heart failure, where we saw evidence that as a result of the audit more patients with heart failure were identified and their care was improved in line with guidance from the National Institute of Health and Care Excellence (NICE). Other audit cycles also showed there had been a positive outcome for patients.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. The GP regularly attended meetings with other GPs in the CCG area, and the practice nurse also met with other practice nurses to discuss best practice in the area.

There was a protocol for repeat prescribing which was in line with national guidance. The GP or nurse carried out a review of patients receiving repeat prescriptions every six months. Where a patient had been discharged from hospital with new medicines the GP had a system in place to review these and ensure records were up to date. We saw that the practice had a high prescribing rate for medicines to help patients sleep. The GP had identified that the majority of these patients lived in care homes and had regular medicine reviews. It was their policy not to prescribe these medicines to new patients.

Effective staffing

There was a small team of staff working at the practice, consisting of one GP, one practice nurse, a practice manager and administrative and reception staff.

Staff training records and discussions with staff demonstrated that they were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. The practice nurse was supported by the practice manager and the GP, who monitored their continuous professional development (CPD). The practice manager told us new staff had always followed an induction programme when they started work. Although no new staff had been recruited for several years there was now a formal induction programme to follow.

We saw that staff had had an appraisal with the practice manager every year. The practice nurse was appraised by the practice manager and the GP. All staff told us they felt supported by the practice manager and the GP and they worked together closely as a team.

The GP had an annual appraisal and had been revalidated in September 2014. They had peer support from a group of GPs in the CCG.

Requires improvement

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services electronically and by post. The GP told us they reviewed the information on the day it was received, took any appropriate action and ensured their patient records were up to date.

The practice nurse met with community matrons and district nurses, and the district nurses attended practice meetings relating to the palliative care of patients. Where a patient was receiving palliative care, information was faxed to the out of hours service so the practice was sure they had up to date information about the patient's condition.

We saw evidence that monthly meetings were held with the local community integrated care team. Participants included practice staff, community matrons and district nurses. Patients with complex needs or at a higher risk of being admitted to hospital were discussed during these meetings, and care plans were put in place where appropriate.

The patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. They told us referrals were made in a timely manner.

We saw evidence that where required patients were referred to other services for care or treatment. Counselling services were available in the area and the GP could refer patients, or they could self-refer. Other services, such as physiotherapy, were available and the practice liaised with these when required.

Information sharing

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice. We saw examples with this when looking at how information was shared with local authority and CCG safeguarding teams.

Some staff preferred to keep hard copies of information. We saw that where they found this easier hard copies were kept securely and the electronic information was still available and could be easily shared appropriately with other services.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment.

The 2014 GP patient survey reflected that 84% of respondents said the GP was good at explaining tests or treatments to them. This was the same as the CCG average. The practice scored better than the CCG average for the GP and practice nurse involving them in decisions about their care.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. People were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. We saw that the practice had various consent forms that were completed appropriately.

The GP and practice nurse told us that patients under the age of 16 very rarely attended without a parent. They were both aware of Gillick competencies but there were no guidelines in place for them to follow in practice. Gillick competencies help clinicians to identify young people aged under 16 who have the legal capacity to consent to medical examination and treatment. The practice nurse told us they would not see a patient under the age of 16 to give them advice about contraception, and would ask them to return with a parent. However, they said they were not a nurse prescriber so were unable to prescribe contraception even if they had given advice. The GP told us that they would see a patient under the age of 16 who attended on their own but they would have a chaperone present throughout the consultation. Young people under the age of 16 who had the capacity to consent were therefore not able to access private appointments.

Health promotion and prevention

We saw that new patients registering with the practice usually met first with the GP. They were provided with a

Requires improvement

Are services effective?

(for example, treatment is effective)

registration form and asked questions about their medical history and lifestyle. They were then invited to attend a new patient appointment with the practice nurse where further details could be given, assessments made, and further appointments with the GP or other healthcare professionals organised if required.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Patients over the age of 40 were invited for a health screening appointment, known as Find and Treat. Their risk of developing a long term illness was assessed and a discussion around their lifestyle took place to see where improvements could be made. The number of patients who attended a Find and Treat appointment had been monitored and patients contacted again where it was felt an appointment would be particularly beneficial.

The patients with the highest risk of being admitted to hospital had a care plan in place. The practice nurse managed these and we saw evidence that they were reviewed at least every three months. We saw that a lot of these patients lived in care homes, and the practice nurse called to see patients at home to explain their care plan and discuss their needs. We saw examples of where the practice nurse had found that referral to other services would be beneficial, and where this occurred the nurse liaised with these services to ensure the patient was seen within an appropriate time period. One example was a patient who had had a stroke and it was found that a physiotherapy appointment had not been made but would help with their recovery.

The practice had almost finished its winter flu vaccination programme. Open surgeries had been arranged so patients could call in for their vaccination. The practice manager kept a list of those patients who would benefit from a vaccination and those who had not called in were contacted. Housebound patients were easily identifiable and the practice nurse visited them to give their vaccinations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with five patients and reviewed 21 CQC comments cards completed by patients at the practice. The majority of feedback was extremely positive. All the patients we spoke with told us they were treated with respect and in a polite manner at all times by staff. Of the 21 CQC comments cards we reviewed, 19 specifically stated that staff were caring, polite and helpful, with several patients commenting that staff remembered their names, which they liked. Patients commented that reception staff went 'above and beyond their duties'.

We observed all staff to be respectful, pleasant and helpful. The staff we spoke with were highly motivated and told us they were encouraged to find ways of meeting the needs of patients. They had all worked at the practice for several years so felt they knew patients and their families well.

Patients told us their privacy and dignity were always maintained during consultations. All patient appointments were carried out in the privacy of an individual consulting room. The GP had a separate examination room off their consultation room.

The practice nurse did not see patients under the age of 16 unless they had a parent present. The GP would see patients under the age of 16 but would have a chaperone present during the consultation. This meant young people under the age of 16 were not given the same level of privacy or respect as other patients.

We looked at the results of the 2014 national GP patient survey. The results showed that 86% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern, and 82% said the same of the last nurse they saw or spoke to. Both these figures were above average for the Clinical Commissioning Group (CCG) area, which were 84% and 79%. In addition 100% of respondents said the receptionists were helpful (CCG average 89%) and 92% of respondents said they would recommend the practice (CCG average 89%).

Care planning and involvement in decisions about care and treatment

The 2014 GP patient survey reported that 80% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care (CCG average 75%), and 71% of respondents said the same of the last nurse they saw or spoke to (CCG average 69%).

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon.

We saw that a wide range of information about various medical conditions was available in the reception area. Information about services that were available in the area was also displayed.

Where patients and those close to them needed additional support to help them understand or be involved in their care and treatment the practice had taken action to address this. Appointment times were not fixed so patients were seen for as long as was required. This meant that where more explanation and discussion was needed the GP or practice nurse was able to do this. Patients highlighted this as a positive part of the practice; they did not feel rushed and felt they were fully informed with all aspects of their care. The GP and practice nurse were aware of their responsibilities under the Mental Capacity Act 2005.

The practice were able to access interpreters where one was required. However, the practice manager and GPs told us they did not currently have any patients who did not speak English as a first language. The GP only saw patients under the age of 16 with a chaperone present and the practice nurse would not see these patients without a parent being present. They did not have the opportunity to be fully involved in decisions about their own care and treatment.

Patients we spoke to 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.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken action to identify and support patients' carers.

A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians and in the reception area.

Patients could be referred to a counselling service in the area. Other services could also be arranged by the GP.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GP moved to the current purpose built practice in 1990 and had been based in other premises prior to this. They therefore knew their patients and their families well. They had always worked as a single handed GP.

The practice was part of a local Clinical Commissioning Group (CCG) network called Tyldesley, Atherton, Boothstown and Astley (TABA). Meetings for TABA members were held monthly with separate meetings for GPs, practice nurses and practice managers. These meetings supported the provision of coordinated care and integrated pathways of care that met patients' needs.

The practice nurse attended monthly risk stratification meetings. These were held with the community matrons and district nurses mainly to discuss patients with a high risk of admission to hospital. Discussions were held about who should manage different aspects of patients' care. These meetings were originally arranged to avoid hospital admissions. However, they had evolved as it was realised the nurses got to know the patients well and were best placed to give to frequent hospital attenders or those who could make better use of services offered by their GP practice.

Where a patient had a higher risk of an unplanned hospital admission a care plan had been put in place. This was managed by the practice nurse who discussed plans with patients, often in their own homes. We saw these plans were updated every three months as a minimum. It was evident from discussion with the practice nurse that they knew all the patients who had a care plan in place and they were able to identify when a risk increased or decreased. We saw evidence that by monitoring the care plans the nurse had identified a patient who would have benefitted from further treatment several weeks after a medical episode. Following this treatment the patient had increased mobility and their risk of an unplanned admission to hospital decreased. The practice nurse told us they did a full update of all care plans regularly and as they knew each patient they were able to notice changes in their condition and act accordingly.

Practice staff knew which patients were housebound and home visits were routinely made for them if they needs any appointment with the practice nurse or GP. The GP told us that prior to any longer holiday weekends they spoke with patients who had been identified as having a particularly high risk of an unplanned hospital admission. This was to ask if there was anything they required. They told us that since they had started to do this the out of hours service had been required to attend less often.

The GPs was single handed so was the lead for specific conditions such as dementia and chronic diseases and the areas of safeguarding adults and children. There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. Also medicine reviews were arranged at appropriate interval for patients who required regular medicines.

The practice was aware of its patient population and kept a register of patients in different groups. A register was kept of patients with special educational needs (SEN), and learning disabilities, and the practice was aware of the different cultures of their patients.

We found the practice was responsive to people'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.

Tackling inequity and promoting equality

The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care. The practice manager told us they had no registered patients who were homeless or travellers. They also did not have any patients who did not speak English. The practice did have systems in place, including a telephone interpreter service, in case the need arose.

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We saw that staff treated all patients as individuals and looking at their specific needs. The practice manager had arranged for staff to attend training in equality and diversity in January 2015 to ensure all staff were aware of their responsibilities.

The premises and services had been adapted to meet the needs of people with disabilities. There was a car park for patients with dedicated disabled spaced. There was also street parking immediately outside the practice. Access to the practice was via a ramp suitable for people using wheelchairs and there were hand rails also. All areas of the practice, which was all at ground floor level, were accessible to people using a wheelchair or pushing a pram.

Access to the service

The practice operated an open surgery system. The GP held two surgeries each day, except Wednesday when the practice closed at lunchtime. Patients who attended during the morning or afternoon surgery were booked in and seen in order of arrival. If there were several patients waiting and a patient attended towards the end of a surgery they were asked if they would like to be seen or attend the next session. No patients were turned away. The staff we spoke with told us patients knew the system and it was busy they often decided to attend a later surgery if they did not have an urgent need.

The practice manager explained that although they did not pre-book appointments patients who worked often telephoned to say they were on their way and would like to be seen. They said that as long as they arrived while the practice was open they were seen, and there was some flexibility about the time the surgery finished if a patient had difficulty attending earlier. The usual closing time was 6.30pm. The practice manager told us they had considered opening on Saturday mornings. However, when this was trialled very few patients attended; their feedback was that the extra opening was not required because patients were seen on demand during the week.

We spoke with five patients during our inspection. They all told us they thought access to the practice was excellent and they were able to attend on the day of their choice and see the GP. They all said that if they needed to contact the practice by telephone they could do this without difficulty.

The 2014 GP patient survey showed that 92% of patients were satisfied with the practice's opening hours (CCG average 80%). It showed that 95% of patients described their experience of making an appointment as good, compared to a CCG average of 79%, and 98% of respondents found it easy to get through to the practice on the telephone, compared to a CCG average of 79%.

Patients who completed CQC comments cards said they liked that they could be seen on the day they attended the practice. Just one patient commented they would prefer to be able to pre-book an appointment.

During October 2014 the practice had carried out a friends and family patient audit. One question asked patients what they liked about the practice. Sixty-seven of the 80 patients who responded specifically said they liked the fact that there was no requirement to book an appointment in advance. None of the patients who responded said they did not like the open surgery system.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager took the lead for complaints at the practice. The senior receptionist also had a lead role in the complaints process because all patients knew them and they were often at the reception desk.

We saw that the practice had not received any complaints in the 12 months prior to our inspection. The most recent complaint was a verbal complaint from September 2013. We saw this was recorded and investigated. A meeting was held with the person who made the complaint and it was recorded they were satisfied with the outcome.

We saw that information was available to help patients understand the complaints system. The complaints policy was displayed on the notice board and there was a leaflet available to inform patients how to make a complaint. All the patients we spoke with said they knew how to make a complaint and would feel comfortable doing so. None had had any reason to do so.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a small, well-established staff team. There was a clear allocation of responsibilities amongst the team.

The practice had a statement of purpose in place that set out the aims and objectives. The staff we spoke with were aware of this and knew what their responsibilities in relation to the statement of purpose were.

The GP, practice manager and practice nurse met regularly with the Clinical Commissioning Group (CCG) to discuss current performance and how to adapt services to meet local demands. The GP was committed to providing a high quality service to patients in a fair and open manner.

The GP did not have any formal succession plans but had given thought to the future with regard to reducing their hours and eventually retiring.

Governance arrangements

There were defined lines of responsibility and accountability for all clinical and non clinical staff. Regular meetings were held that included clinical and non clinical staff. We looked at the minutes of recent meetings. These were brief but provided evidence that performance, quality and risks had been discussed with information disseminated to staff.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. The clinical audits we saw showed that they had had a positive impact on patient outcomes.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically and on paper. The policies and procedures we looked at had been reviewed annually and were up to date.

Leadership, openness and transparency

Although the practice was small, with a single handed GP, roles were defined and the GP was the overall lead for most aspects of the running of the practice. They worked closely with the practice manager. We spoke with staff members and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. The staff team had worked together for many years and there was a very low turnover of staff and a low sickness rate.

We saw from minutes that team meetings were held regularly. Some of these were informal but more structured formal meetings were held every two to three months. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time. They told us the practice manager and GP were very supportive and approachable.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies 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 previously gathered feedback from patients though satisfaction surveys. We saw the results of the survey carried out in 2013 which showed all respondents rated the practice as excellent or very good. When asked about their satisfaction with the opening hours 94% of respondents rated them as excellent or very good with the remaining 6% rating them as good.

The practice had carried out a friends and family patient audit during October 2014. This asked for the aspects of the practice patients liked or did not like. We only saw one of the 80 patients who had responded had made a negative comment and suggested improvement.

The practice manager explained that they had tried to start a patient participation group (PPG) but had been unable to recruit members. They had tried various ways of raising patients' awareness and currently explained why a PPG

Are services well-led?

Good

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

would be beneficial to all new patients when they registered with the practice. Two of the five patients we spoke with were aware of the practice's attempts to form a PPG. The practice manager hoped to be able to from a small PPG group in the future.

The practice welcomed feedback from patients and we saw positive feedback had been given by way of 'thank you' cards. We saw that where issues or ways to improve had been highlighted, from the results of previous surveys or complaints, action was taken, but few concerns had been identified. The patients we spoke with said they would feel comfortable raising concerns but were happy with the service provided.

The staff we spoke with told us the practice manager had an open door policy and they were encouraged to make suggestions about how the service could be improved. There were opportunities to put forward their ideas during the regular formal or informal practice meetings, and also during their more formal appraisal meetings.

Management lead through learning and improvement

Staff told us they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. They said they were supported in their personal development. Formal appraisals took place annually. Staff were asked to complete a proforma prior to their appraisal and identify if any additional learning or support was required. They told us the GP and practice manager were very supportive in all aspects of their work.

We saw evidence that the continuing professional development (CPD) of the practice nurses was monitored by the GP and recorded. They were able to obtain clinical advice from the GP at any time.

The GP was supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), indicated that they were up to date and fit to practice. The GP and practice nurse regularly attended meetings with the CCG so that support and good practice could be shared.

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

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Suitable arrangements were not in place to ensure the dignity, privacy and independence of all patients, or to ensure all patients could participate in making decisions relating to their care or treatment. Not all patients were treated with consideration and respect.** Regulation 17 (1) (a) (b) (2) (a)