Dr Hara Chakrabarti

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Chakrabarti Surgery on 22 April 2015.

Overall the practice is rated as good. We found the practice to be good for providing safe, well-led, effective, caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and staff.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We also saw areas of outstanding practice:

- The practice had a nurse who worked across three practices who assisted with the care of the over 75 age group population within the practice. This nurse carried out home visits and dementia assessments in the patient's own home.

Summary of findings

- The practice offered a separate area to nursing mothers to breast feed their babies; mothers could access this area at any time during surgery hours.

In addition the provider should:

- Ensure staff awareness relating to serious adverse incidents is raised and they are empowered to complete the documentation themselves rather than asking the practice manager to do this.
- Ensure re-audit dates are documented on all audits to ensure the full cycle is completed and reported upon.
- Ensure communication with the multi-disciplinary team is formally recorded and strengthen links with this team.
- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.

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, report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Staff were knowledgeable about what constituted a safeguarding concern. The lead GP took the position of safeguarding lead for the practice and staff knew who to contact.

Recruitment checks were conducted for all new staff.

Risk management and information relating to safety was monitored, reviewed and addressed. There was sufficient staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Care and treatment was delivered in line with current published best practice. Staff meetings and audits were used to assess how well the service was delivered.

Consent to treatment was always obtained where required and this was confirmed when speaking with patients.

Clinical Commissioning Group (CCG) data showed patient outcomes were in line with the average for the locality. National Institute of Health and Care Excellence (NICE) guidance was referenced routinely.

Staff had received training appropriate to their roles. The practice undertook appraisals for staff and we were shown an on-going programme for this.

The practice regularly met with some health professionals and commissioners in the local area in order to review areas for improvement and share good practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from patient surveys showed patients rating of the practice were variable for several aspects of care. Patients said they were treated with compassion, dignity and respect. They were involved in planning for their care and treatment. However only 49.5% would recommend the practice to others.

Summary of findings

We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care.

Staff were familiar with patients and recognised when patients needed extra support or assistance and strived to ensure this need was met.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services.

The practice reviewed the needs of their local population and engaged with the NHS England Local Area Team (LAT) and the Clinical Commissioning Group (CCG) to secure service improvements where possible.

Patients reported good access to the practice. Appointments were available the same day.

The practice sought to gain patient feedback through verbal communications, the use of suggestions boxes and the friend and family NHS test.

We saw evidence that complaints were responded to quickly and that staff were involved in discussions around ways to improve. The practice reviewed complaints on an annual basis to identify any recurrent trends.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The practice had a clear vision which had quality patient care as its top priority. An imminent move to more appropriate premises was clearly communicated to all staff and patients.

High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Governance and performance management arrangements were proactively reviewed. We found there was a high level of staff engagement with an open door policy for access to all senior staff. Staff told us they were very satisfied with their roles. The practice sought feedback from patients and staff and acted upon it where possible.

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 7.1% of the patient population were aged 65 or over which was below the national average. The practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, avoidance of unplanned admissions to hospital, timely diagnosis and support for people with dementia, and a shingles vaccination programme for those aged 70 and above. The practice was responsive to the needs of older people including offering home visits. The practice had used Clinical Commissioning Group resources to employ a nurse shared between three local practices to create extra session and home visits for this age group, this allowed for dementia screening in the persons own home and familiar environment.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There was a high prevalence (47.6%) of patients with long standing conditions, such as cardiovascular disease and Chronic Obstructive Pulmonary Disease (COPD) amongst the patient population. Nursing staff had received appropriate training which enabled them to focus upon specific chronic conditions and appropriately assist in the management of them through a comprehensive schedule of clinics. These patients were recalled annually which ensured they had structured annual reviews to check their health and medication needs were being met.

GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care for those patients with the most complex needs. The practice offered enhanced services to meet the needs of patients with long-term conditions such as avoidance of unplanned admissions to hospital through care planning.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following up children who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation clinics for babies and young children were available on a weekly basis. Appointments both routine and urgent were available outside school hours and the premises were suitable for children and babies. Children needing urgent appointments were seen as soon as

possible at the surgery. Children and young people were treated in an age appropriate way and recognised as individuals. Monthly Health Visitor and GP meetings were held to discuss any concerns or safeguarding issues. The population group of under 18 year olds accounted for 53.9% of the practice patient population which is higher than both the Clinical Commissioning Group (CCG) and national average for this age group.

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 this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. Patients were able to book appointments and request repeat prescriptions using online facilities. A full range of health promotion and screening services were available which reflects the needs for this age group was available within the practice. Telephone triage services were arranged at a time to suit the patient if patients were working and felt they needed advice from the GP. Late night appointments were available until 7pm on Tuesday and Friday evenings.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with learning disabilities. Patients with learning disabilities were offered annual health checks and longer appointments were available if required. The practice effectively supported carers who were sometimes vulnerable themselves alongside the person they were caring for.

The practice worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise the 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 care of people experiencing poor mental health (including people with dementia). Patients within this group received a timely recall for their annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service available.

Summary of findings

The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia which they were actively working to improve upon. This included employing a nurse shared between three local practices to create extra session and home visits for the elderly, this allowed for dementia screening in the persons own home as a familiar environment.

Staff told us the practice had sign-posted patients experiencing poor mental health to various support groups, and they were proactive in helping patients address issues to improve all aspects of their health.

Summary of findings

What people who use the service say

We received 43 completed Care Quality Commission (CQC) comment cards which included feedback from male and female patients across a broad age range and spoke with four patients from a variety of cultural backgrounds during the inspection. Patients spoke positively about the practice, and the care and treatment they received. All patients commented on the practice environment. They told us it was always safe and clean.

Out of all the comments cards we received, we had four cards which contained negative comments which we discussed with the GP. Negative comments included one patient saying they had a difficulty with one member of the team so usually spoke with another member of staff. The GP and practice manager were aware of this difficulty and were actively managing this.

Patients commented they were fully informed regarding the upcoming move to new premises and had been asked for their comments. All the patients we spoke with felt the move was a positive step for the practice.

One patient told us about the availability of a private breast feeding room and told us they had accessed the facility when they were not seeing the GP but were in the area and their child needed feeding. This facility was clearly displayed on the notice boards in the waiting area.

Patients descriptions of staff included helpful, friendly, thorough and kind. Patients told us staff understood and they were treated with dignity, compassion and respect.

Patients felt involved in planning their care and treatment. Patients told us urgent appointments were always available. They told us on the whole they did not struggle to get appointments.

The practice did not currently have an active patient participation group despite advertising for people to join the group. We were shown details of recent interest from a professional patient from the local community and the practice were currently discussing with this patient how they could encourage other patients to join the group.

Results from the 2014 National GP Survey rated the practice as satisfactory against other practices in the area, with ratings from patients being below the averages for the Clinical Commissioning Group. However 85% of patients who responded indicated they were satisfied the GP listened to them and 88% said they had enough time with the GP during the consultation. 94% had confidence and trust in the GP, with 100% having confidence in the nurse.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff awareness relating to serious adverse incidents is raised and they are empowered to complete the documentation themselves rather than asking the practice manager to do this.
- Ensure re-audit dates are documented on all audits to ensure the full cycle is completed and reported upon.
- Ensure communication with the multi-disciplinary team is formally recorded and strengthen links with this team.
- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.

Summary of findings

Outstanding practice

- The practice had a nurse who worked with three other practices who assisted with the care of the over 75 age group population within the practice. This nurse carried out home visits and dementia assessments in the patient's own home.
- The practice offered the facility of a separate area to nursing mothers to breast feed their babies; mothers could access this area at any time during surgery hours.

Dr Hara Chakrabarti

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP and a specialist practice manager advisor

Background to Dr Hara Chakrabarti

Dr H Chakrabarti Surgery is situated close to the city centre of Preston in a residential area. There are currently 1850 patients registered with the practice. The practice held a General Medical Service (GMS) contract with NHS England to deliver Primary Care Services to the local community.

The patient population groups are all lower than the Clinical Commissioning Group (CCG) and National averages except for the age groups under 18 years which were higher than both local and national averages. This practice has a minimal annual turnover of patients. Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice team comprises of one GP and a locum GP two days per week both male, at present there was no access to a female GP. There was a part time practice nurse with a variety of skills and qualifications. The practice manager was supported by a team of reception and administrative staff. The practice did not at present have an active patient participation group.

Opening hours are 9am-6pm Monday and Wednesday, until 7pm on Tuesday and Friday and the practice closed Thursday afternoon. Surgeries are available mornings, afternoons and evenings. When the practice is closed an out of hours service, Preston Primary Care Centre, meets the care and treatment needs of patients.

The practice informed us their estimate for patients from diverse ethnic population groups registered with the practice was approximately 74% of their practice population.

The practice has imminent plans to move to newly adapted premises which they will share with two other practices, just a short distance from where they are currently situated. We were shown the plans for the new premises and could see the layout was user friendly and more open than current facilities. The move should have taken place at the beginning of April 2015 but had been delayed until June 2015. Patients and staff were fully aware of the planned move.

Why we carried out this inspection

We carried out 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:

Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our previous inspection. We also asked other organisations to share what they knew. The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 22nd April 2015. During our visit we spoke with GPs, the practice manager, patients, reception and administrative staff. Due to annual leave we spoke to the practice nurse in advance of the inspection to get her comments. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Including investigating reported incidents, checking national patient safety alerts and sharing 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. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

We saw the practice had an accident book where staff could report accidents that occurred within the practice. The nurse was responsible for ensuring accidents were recorded and appropriately dealt with when she was available otherwise the GP took responsibility for this. We saw only one accident had been recorded within the last six months.

Minutes of clinical team meetings provided clear evidence that incidents, events and complaints were discussed and where appropriate actions and protocols were identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. Significant events were a standing item at the practice staff meeting. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff we spoke with, including receptionists, administration and nursing staff, knew how to raise an issue at the meetings and they felt encouraged to do so. We found staff did not record incidents themselves they relied on the practice manager to complete the documentation after they had verbally informed her of the issue. The practice manager should ensure staff awareness relating to serious adverse incidents is raised and they are empowered to complete the documentation themselves. We also found some incidents were held by individual clinicians (ready for use at their appraisals) and not stored centrally however the practice manager could demonstrate the incidents had been discussed at staff meetings.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their ongoing professional development. Where required changes to protocols and processes were implemented. One significant event was discussed with the team regarding a patient who overheard a conversation between reception staff regarding one of the staff relatives and the patient thought they were discussing the patient's relative. As a result of this, changes were made to the waiting area and all patients were asked to wait in an area away from the reception desk so try to ensure patients could not overhear both personal and professional conversations. Whilst this has been effective it has caused some cultural issues with some of the community with male and female patients waiting in the same area, this it is hoped will be addressed when the practice moves to their new premises and has a larger waiting area..

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance that were relevant to the care they were responsible for.

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 understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The lead GP acted as lead 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. All staff we spoke with were aware who these lead was and who to speak with in the practice if they had a safeguarding concern. All other staff were trained to a level appropriate to their role.

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 children subject to child protection plans.

Effective working relationships and monthly meetings with the health visitor allowed the practice staff to ensure their vulnerable children's register was kept up to date.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice nurse acted as chaperone where available otherwise staff who had undergone training acted in this role to support patients were requested.

Medicines management

We checked medicines stored in the nurses consulting room and fridge. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines.

We found medication carried in the GPs home visit bag was checked monthly and was all in date.

All medicines that we checked were found to be in date.

The fridges used for the storage of the vaccinations were designated pharmaceutical fridges. The electricity plugs for the fridges were located out of sight behind the fridges which reduced the risk of them being inadvertently disconnected

The GP reviewed their prescribing practices as and when medication alerts or new guidance was received. We saw from data produced at CCG level that audits were carried out by the CCG medicines management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

All prescriptions were reviewed and signed by a GP before they were given to the patient or sent electronically to the pharmacy chosen by the patient. The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. The practice processed repeat prescriptions within 24-48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs.

We checked the prescription box and found a number of prescriptions were over a month old the practice manager assured us these were dealt with regularly and patients contacted to check if they still required the medication. The practice manager informed us patients sometimes requested repeat prescriptions then went on holiday or to stay with another family member and did not collect the prescription.

Good

Are services safe?

Security measures were in place for prescriptions within the practice, access was in line with suggested best practice within the NHS Protect Security of prescription forms guidance, August 2013. We were told hand written prescriptions were rarely used however these were not tracked fully. The practice assured us after discussion they would ensure all prescription numbers from these pads were recorded and audited on a monthly basis.

Emergency medicines for cardiac arrest, anaphylaxis, meningitis and hypoglycaemia were available within the practice. We checked the emergency drug box and saw that medicines were stored appropriately and were in date. We found the practice did not have a defibrillator available or access to oxygen for use in emergency, the practice made use of 999 to summon assistance in an emergency situation. The practice manager had risk assessed this and found the ambulance response time was nine minutes but the emergency paramedic responder could be on site within three minutes. We saw other medicines stored within the practice were in date and robust systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

All staff carrying out home visits carried mobile phones in case the patient did not have a phone line at their home. The nursing team had a stocked anaphylaxis medicine box which they took out when visiting patients in their home for flu vaccinations. This was checked and was all in date.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Comments recorded by patients on CQC comment cards referred to the practice as being clean hygienic and safe.

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. Staff received training about infection control specific to their role The lead for infection control checked and audited the practice to ensure staff followed procedures. Any actions from the audit had been actioned in a timely manner. Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couch covering and privacy curtains were disposable in the treatment rooms and the couch cover was changed following each patient use.

We were told the practice only used instruments that were single use. Procedures for the safe storage and disposal of instrumentation, sharps and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored appropriately.

Staffing and recruitment

The majority of staff were long standing and had been employed at the practice for more than eight years. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment of new staff. 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. DBS checks were planned to update the records held on the GP and the locum GP.

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw

evidence that demonstrated professional registration for clinical staff was up to date and valid. We saw checks on Medical Defence Union Insurances were checked annually and records kept supporting this.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning. However we found during the nurses annual leave there was no provision for patients, we were assured once the move to new premises was complete the practice would be able to access other practice nurses should the need arise.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose. Some staff had dual roles that encompassed a number of roles.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. All new employees working in the building were given induction information for the building which covered health and safety and fire safety. All staff had access to a staff handbook.

There was a health and safety policy available for all staff which included both general workplace and clinical policies and procedures for staff follow.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment safety checks and fire drills to ensure the safety of patients, staff or visitors were available. The practice manager could demonstrate a recent fire evacuation process had been carried out without issue. Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

Arrangements to deal with emergencies and major incidents

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system and within the clinical rooms there were buttons on the wall.

An appropriate business continuity plan/ disaster recovery plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plans and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually and was due at the time of the inspection. There were suitable emergency medicines available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia and suspected meningitis. 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients spoken with said they received care appropriate to their needs. They told us they were included as much as possible and were helped to come to decisions about the treatment they required.

New patient health checks were carried out by the practice nurse and cardiovascular and other regular health checks and screenings were ongoing in line with national expectations.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach. Patient education had proved to be a difficult process with the population groups of the practice however the practice nurse had been successful in encouraging women to attend for cervical smear monitoring with only 1% of eligible patients at the practice refusing to attend for regular monitoring.

Care plans had been put in place for 2% of the practice patients who met the criteria to avoid unplanned admissions to hospital. This was part of local enhanced services and GPs had initiated the plans with patients in their own home and included their family and/or carers where appropriate.

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurse we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Multi-disciplinary meetings were currently not held regularly to discuss patients but were held on an ad-hoc basis due to work commitments. These meetings were structured to ensure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included evaluations of medicines for people with high blood pressure where treatment was changed if required so that the best outcomes could be achieved. Further audits of minor surgery results outcomes, waiting times in the surgery and an audit of patients with multiple medications had been completed within the last 12 months.

The practice reviewed patients under a locally enhanced service to minimise unplanned admissions to hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments.

The practice had used Clinical Commissioning Group resources to employ a nurse shared between three local practices to create extra sessions and home visits for this age group, this allowed for dementia screening in the persons own home and familiar environment.

The GPs undertook minor surgical procedures within the practice in line with their registration and NICE guidance.

Regular monthly meetings took place with the health visitor team to share information and provide reflection and learning to the benefit of the patients. Regular meeting with the multi-disciplinary team (MDT) had been sporadic in recent months due to workload however the GP assured us once they move to the new surgery premises there was a plan to reinstate all MDT meetings.

Effective staffing

All the staff at the practice were very complimentary and satisfied about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. Most staff were multi-skilled and able to carry out the role of their colleagues as required to cover absence.

Most of the staff were long serving. There was an induction process for new staff which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care.

Good

Are services effective?

(for example, treatment is effective)

Doctors were revalidated, nurse professional registrations were up to date and appraisals were carried out annually on all staff.

All patients we spoke with were complimentary about the staff and we observed staff who were competent, comfortable and knowledgeable about the role they undertook.

There was enough staff to meet the demands of the practice at the time of the inspection, however we were told there had been some challenges in recent months but the staff had worked together to address this.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services to maintain safe and effective care for their vulnerable patients.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hour's service in relation to patients receiving palliative care and if patients had signed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms. The practice had a close working relationship with the local out of hour's service.

The practice had a close working relationship with Greater Preston Clinical Commissioning Group (CCG) and worked collaboratively on a number of local initiatives.

CQC comments cards confirmed patients felt they had been referred for hospital appointments within an appropriate timescale. Patients we spoke with said that if they needed to be referred to other health providers they were sure this would be discussed with them fully at the time.

The GP was currently working closely with other practices in the locality to come together in the new premises and share good practice and processes to avoid repetition of tasks.

Information Sharing

Information about significant events was shared openly and honestly at practice meetings. The GP attended CCG meetings and shared what they had learned in practice meetings. This kept all staff up to date with current information around local enhanced services, requirements in the community and local families or children at risk.

There was a practice website with information for patients including signposting, services available and latest news. There were numerous information leaflets available within the practice waiting room and at the request of any of the clinicians if a patient required more private information.

The practice used both electronic and fax systems to communicate with other providers. For example, they faxed information to the local out of hour's provider to enable patient data to be shared in a secure and timely manner. The out of hour's services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated.

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent.

Patients were discussed between the practice clinicians and also with other health and social care professionals as required.

All staff completed mandatory training which included; information governance (IG) and confidentiality training.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GPs and the nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.The GP told us they had received training in regards to consent and had received formal training for the Mental Capacity Act 2005 (MCA). GPs

Good

Are services effective?

(for example, treatment is effective)

and the nurse were aware of the MCA and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

The practice policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate.

The 2014 national GP patient survey indicated 73% of people at the practice said the last GP they saw or spoke to was good or very good at explaining tests and treatments, 77% said the last GP they saw or spoke to was good or very good at treating them with care and concern and 100% had confidence and trust in the last nurse they saw or spoke to.

Staff informed us they had access to interpreter translation services for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use. Staff within the practice spoke a variety of different languages and could assist the patients as required.

Health Promotion & Prevention

All new patients were offered a consultation and health check with the nurse. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice offered NHS Health Checks to all patients aged 40 to 74 years old.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

The practice website and surgery waiting areas provided a variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle.

The waiting room had been moved to address an issue raised in patient feedback. The area was well organised with notice boards for individual health issues which were easy to read and had straight forward directions and advice on them. There were a wide range of leaflets available to patients and these were available in local dialects as required.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 4 patients on the day of our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff.

Comments left by patients on the 43 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, respectful, understanding, helpful, friendly and comforting. However four of the comments cards contained some negative comments when we discussed these with the senior management team they were aware of the issues and were actively dealing with them.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. However when we sat in the waiting area we could hear some of the conversation in the nurses consulting room. We brought this to the attention of the GP who assured us in the new premises the consulting rooms were away from the waiting and reception areas.

There were signs, both in the waiting room and in the consultation rooms explaining that patients could ask for a chaperone during examinations if they wanted one. Patients we spoke with were aware that chaperones were available.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead.

Phone calls were taken at the front reception desk and staff were aware of how to protect patient's confidential information. We observed staff identifying patients by date of birth rather than name or address to maintain confidentiality.

There was a room available if patients wanted to speak to the receptionist privately, although this was not advertised.

The practice did not currently have an active PPG, however we were shown recent communication with a patient who had highlighted they would be happy to join the group and actively assist the practice to recruit other members.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that they felt involved in decisions about their care and treatment. Patients told us treatment options was clearly explained and they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do. Another patient said the GP always took time to understand and discuss their issues in their own language, and answer any questions they may have. They were satisfied with the level of information they had been given.

Care plans were in place for patients on palliative care and the GP supported patients with discussion about end of life preferences as appropriate. These care plans were kept up to date and shared with relevant healthcare professionals such as the out of hours (OOHs) service.

Using a coding system on the computer system the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities. With the involvement of the patient, care plans had been put in place for anyone at increased risk of admission to hospital.

All the staff we spoke with were effective in communication and all knew how to access an interpreter if required. Information could be accessed in different languages as and when required.

We looked at the consent policy and spoke with clinical and administration staff about consent. We saw the policy provided clear guidance about when, how and why patient consent should be requested. There was reference to children under the age of 16, patients with limited capacity and chaperoning requirements. All clinical staff had completed training regarding the Mental Capacity Act 2005 appropriate to their roles.

The 2014 GP patient survey reported that 78% of respondents said the last GP they saw or spoke to at the

Good

Are services caring?

practice was good at involving them in decisions about their care. 84% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The practice had systems in place that reflected best practice for patients nearing the end of their life and demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told that in appropriate cases GPs had conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation with patients. This was to ensure patient's wishes were managed in a sensitive and appropriate way. The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which are valid and follow the patient through any health care environment.

Multi-disciplinary meetings with the palliative care team were currently not held on a regular basis however the practice only had two patients on the palliative care register so these patients were discussed as required with the GP and the team caring for them. Patient preferences were shared electronically with appropriate healthcare partners to ensure they were met, for example, with the out of hour's services.

The practice had a display of information for carers which provided signposting to support on a wide variety of issues.

Bereavement support was available monthly and the notice boards in the waiting area clearly identified dates for this support. We were told the GP contacted all bereaved families and offered support and condolence as soon as he was aware of the family death.

The 2014 GP patient survey reported that 85% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 91% said the last nurse they saw or spoke to at the practice was good at listening to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due.

The NHS Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and had identified service improvement plans.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurses to receive their influenza vaccinations.

Practice staff pro-actively followed up information received about vulnerable patients.

Patients were able to access appointments on the day should this be required. The practice offered a triage service whereby the GP rang the patient back at a pre-arranged time and discussed their needs and then either requested they attend the practice of offered alternative advice or a prescription if appropriate.

Longer appointments could be made for patients such as those with long term conditions, learning disabilities or who were carers.

The practice had also implemented suggestions for improvements where possible in response to feedback from the patient. The practice manager told us the practice was proactively trying to gain feedback from patients and trying to encourage more patients to join the group in order to determine how to improve and meet the needs of the population it served.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice 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.

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service. The practice did not at present have regular meetings with the mental health team for the area but did receive information regarding patient attendance at the local NHS Mental Health Service.

An interpreter service was available if required and electronic process; however we were told this was seldom used.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site. The practice operated a choice of same day appointments and those which could be booked in advance.

70% of respondents to the 2014 GP patient survey said that they were satisfied with the practice opening times. With only 33% saying the practice was easy to get through to by telephone.

From the CQC comment cards completed and speaking with patients we were told appointments were usually on time with not too much waiting. One patient told us they experienced problems contacting the practice at times but if they waited 10 minutes they could get through no problem. They did also say they were confident if they needed seeing on the day they would be seen at some point.

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or for patients with learning difficulties and mental health issues to ensure time was appropriately spent with patients. The GP assured us if patients once in their consultation required extra time this would be given and he would explain and apologise to subsequent patients why there had been a delay. He felt this had always been effective for the patients. 86% of patients felt the GP gave them enough time.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

We reviewed how the practice managed complaints within the last 12 months. Two complaints had been made by patients or family of patients. We found the practice handled and responded to complaints well. Complainants always received acknowledgement of the complaint and complaints were investigated and documented in a timely manner as required.

Investigations addressed the original issues raised and action was taken to rectify problems.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

Dr Chakrabarti's Practice did not have a written strategy however it was evident that all staff within the practice worked to the same ethos. Staff had been working at the practice for a number of years and had been part of the changes, challenges and development of the move to new premises.

All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the GP, practice manager and the practice staff. We saw evidence that showed the GP and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

Governance arrangements

There were clear lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. The minutes showed what actions needed to be taken and who was responsible.

It was evident that staff were able to raise concerns in a constructive and fair manner. Staff were able to describe how they would raise any concerns and explained how feedback and action was disseminated to staff in a constructive manner.

The practice participated in the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing well against national standards. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The culture at the practice was open and fair. Staff told us they felt comfortable raising any issues or concerns and that they had the opportunity to discuss with any member of the senior management team.

The practice had up to date policies in place to support staff. Staff we spoke with knew where to find these policies if required.

Staff said they were supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to the GP if they felt they had any worries.

Staff from the practice also attended the CCG protected learning time (PLT) initiative. This provided staff with dedicated time for learning and development. The team met monthly to discuss any significant incidents

The practice prided itself on having a 'no blame' culture and staff commented this reassured them.

Practice seeks and acts on feedback from its patients, the public and staff

The practice actively sought feedback from patients through patient surveys and complaints received. We looked at the results of the 2014 GP patient survey. The surveys reflected variable levels of satisfaction with the care, treatment and services provided at the practice. However where issues were identified action had been taken to address them.

Despite many invitations the patient participation group had not been successful. Reception staff had been involved in this recruitment by asking patients if they were interested in joining the group.

The practice gathered feedback from all staff through discussion and their open door policy. When we looked at staff files it was clear that individual performance was monitored and that personal and professional development was encouraged.

Management lead through learning and improvement

GPs were supported to obtain the evidence and information required for their professional appraisal and revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The GP was involved in the local clinical meetings.

Similarly the practice nurse and practice manager regularly attended their professional forum groups established by the CCG and locally set up to provide training and support and share good practice.

Are services well-led?

Good

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

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge.

The GP discussed the challenges for services whilst experiencing funding changes however the practice aimed to be innovative and participate in future locality developments, working closely with other practices in a federated style in the new location.

The practice completed reviews of significant events and other incidents and shared with staff to ensure the practice learned from and took action, which improved outcomes for patients.