Dr Chandra Khatri

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Chandra Khatri on 21 March 2016. Overall the practice is rated as requires improvement.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. .
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs through an extended network of multidisciplinary professionals.
- New patients who were prescribed hypnotic drugs received dedicated one-to-one support to reduce their dependence on these over an eight week period.
- A dedicated, highly trained practice nurse offered a wide range of specialist clinics and individualised support to patients with long-term and complex conditions.
- The practice nurse actively engaged with patients who were vulnerable or who had mental health needs to reduce the number of unplanned admissions to hospital.

The areas where the provider must make improvements are:

Summary of findings

- Implement fire safety training and fire drills for all staff.
- Review the security of the premises, to include restricted access to the treatment room and vaccines.
- Update staff training records and ensure all staff are trained appropriately to meet their responsibilities.
- Implement annual appraisals of each staff member and ensure they receive regular supervision commensurate with their role.
- Ensure accurate and up to date information is available to patients on how to make a complaint.

The areas where the provider should make improvements are:

- Review staff support and retention practices, including evidencing that staffreceive a thorough induction programme.
- Develop a patient participation group.
- Improve access to interpreter services.
- Improve the management of sharps collection bins
- Implement cleaning schedules for all areas of the practice
- Improve access to the Business Continuity Plan by having a back up paper copy.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared in relation to most incidents to make sure action was taken to improve safety in the practice. However we identified an example where the learning and actions process was not completed.
- Medicines were managed and stored appropriately and staff accessed expert advice when needed. There was room for improvement in the control of access to vaccines.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Fire safety procedures required improvement.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.
- Staff training was intermittent, poorly documented and inconsistent.
- Appraisals and supervisions rarely took place and where they did this was sporadic and failed to address staff professional or competency needs.
- Inductions for new staff were poorly documented and it was not possible to establish that each member of staff had received an induction adequate for their responsibilities.
- Evidence of health promotion interventions was limited to the practice nurse and GPs engaged in this opportunistically and without an established structure.

However, we found a number of areas of good practice:

- Data showed patient outcomes were comparable to or higher than the England average. This included care of people with diabetes and patients with a diagnosis of psychosis.
- Knowledge of and reference to national guidelines were consistently good.

Summary of findings

Although audits were limited, there was evidence they were driving improvement in patient outcomes, such as in the reduction of prescribing antibiotics

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the clinical commissioning group to secure improvements to services where these were identified. This included in medicines management for patients with long-term conditions.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Learning from complaints was shared with staff and other stakeholders but there was room for improvement in how patients could access the complaints policy.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice did not have a coherent vision or strategy and staff told us short staffing meant their primary focus was on maintaining the service as it was. There was a documented leadership structure but due to changes in staffing and high levels of sickness, this rarely worked in practice. Staff told us they felt supported and had someone to speak with when they needed help but this was unstructured and informal.
- The practice had a number of policies and procedures to govern activity, but some of these were not detailed enough.

Summary of findings

- All staff had received inductions but standards were variable. Not all staff had received regular performance reviews or attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for this population group.

The practice is rated as requires improvement for the safe, effective, and well led domains, and good for responsive and caring. The concerns which led to these ratings apply to everyone using this practice, including this population group.

- A dedicated healthcare assistant offered health checks to all patients who were aged 75 or over. This included a care plan based on individual needs, such as if the person lived alone or had areas of social concern such as a risk of self-neglect.
- Clinical staff had access to a multidisciplinary community team of professional support staff, including a community matron, social services, occupational health and a falls assessment team.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for this population group.

The practice is rated as requires improvement for the safe, effective, and well led domains, and good for responsive and caring. The concerns which led to these ratings apply to everyone using this practice, including this population group.

- The practice had a higher number of patients with long-term conditions than the England average of 58%. All patients with a long-term condition were invited to an annual review and people with diabetes, asthma and ischemic heart disease were offered more frequent review appointments.
- The practice nurse managed the routine health of people with the need for chronic disease management and attended a comprehensive programme of annual professional development to be able to do so. This included the care and condition management of patients with acute kidney injury, chronic obstructive pulmonary disorder, incontinence, epilepsy and angina. This member of staff was able to offer a spirometry service to help diagnose and monitor lung conditions.
- Diabetes specialist nurses, respiratory nurses and cardiac nurse specialists were available locally to provide additional support to patients.

Summary of findings

- Patients with diabetes could be referred to Diabetes Education and Self Management for On going and Diagnosed (DESMOND) education course by the practice nurse to empower them to increase control over their diagnosis
- Nurse-led clinics were available for people with chronic obstructive pulmonary disorder, diabetes, dementia and asthma. Patients with asthma received coaching and education on trigger factors, inhaler use and allergy symptom relief by the practice nurse who undertook annual training updates.
- The practice had established a good relationship with a community pharmacist, who visited on demand for people who were prescribed complex medication.
- Staff planned how they would meet the needs of new patients who had been diagnosed with cancer at monthly meetings to help coordinate their care.
- All patients with a long-term condition received additional holistic lifestyle advice from appropriately trained staff in areas such as diet, weight management, alcohol intake and smoking.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for this population group.

The practice is rated as requires improvement for the safe, effective, and well led domains, and good for responsive and caring. The concerns which led to these ratings apply to everyone using this practice, including this population group.

- GPs and the practice nurse offered a range of clinical service including a regular clinic for contraception as well as antenatal and postnatal care. The community midwife held a weekly clinic at the practice and was able to facilitate the hospital of choice for each patient's delivery. Practice services also included neo-natal checks, breastfeeding advice and new parent support.
- The practice nurse offered a weekly baby clinic and was able to refer people to a local health visitor for home visits. This member of staff also offered childhood immunisations, which were completed at a rate comparable to or better than the England average in all but one area. The practice nurse completed annual refresher training and updates in line with Public Health England and Royal College of Nursing guidelines.
- A GP offered a six-week check-up for new born babies as well as post-natal appointments for new mothers.
- Children with complex needs, including complex social needs, were supported by a multidisciplinary team that included social services.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for this population group.

The practice is rated as requires improvement for the safe, effective, and well led domains, and good for responsive and caring. The concerns which led to these ratings apply to everyone using this practice, including this population group.

- Although the practice saw a lower number of working age people in employment than the England average of 53%, a higher than average number of patients were unemployed. Staff had a good understanding of the health promotion needs of this patient group.
- Later appointments with the practice nurse or a GP were available four days per week, including until 8.45pm on Mondays to enable better access for people who worked office hours. Later appointments were booked as an extended slot to enable GPs to spend more time with registered patients they would rarely otherwise see.
- Patients aged 40-74 were offered an NHS Health Check, which was used to identify previously undiagnosed conditions such as high cholesterol, anaemia and hypothyroidism. The checks were also used to identify people at risk of developing diabetes in the future.
- The practice offered travel vaccinations and the practice nurse completed annual update training in line with guidance from the Public Health England and Royal College of Nursing guidelines.
- The practice nurse had undertaken training in the support of female patients during menopause and those receiving hormone replacement therapy (HRT).

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for this population group.

The practice is rated as requires improvement for the safe, effective, and well led domains, and good for responsive and caring. The concerns which led to these ratings apply to everyone using this practice, including this population group.

- Staff used a multidisciplinary approach to provide care and support for people who were vulnerable, including care coordinators, social services, district nurses, mental health workers and counsellors.

Summary of findings

- The practice nurse offered specialist clinics for smoking cessation, weight management and for people who were concerned about their alcohol or drug use. Staff were able to rapidly refer to a local recovery and rehabilitation service. This member of staff was also able to support patients to develop a more active lifestyle following specialist training.
- Patients with a brain injury, learning disability or sensory disability were monitored by clinical staff at the surgery who engaged with multidisciplinary specialists to manage their needs.
- Staff understood the risks relating to vulnerable people and unplanned hospital admissions or readmissions. To mitigate this, they provided substantive information to each patient on the purpose of other services, such as walk-in centres and hospital emergency departments.
- Staff had access to a drugs counsellor to support them in providing care for people with needs relating to addiction.
- The practice had seen an increase in new patients whose first language was not English and who found it difficult to communicate as a result. Where previous medical notes were not immediately available, staff engaged with other healthcare providers to try and trace information. Although translation services were available, these did not always work well in practice and we found confidentiality was sometimes at risk because staff would ask a family member to act as an interpreter, instead of using an independent professional.
- Clinical staff demonstrated an excellent awareness of the needs of vulnerable patients in situations where safeguarding was a concern, such as when a person under the legal age of consent asked for contraception.
- Staff demonstrated an excellent understanding of safeguarding protocols, including good links with the local safeguarding team and health visitor where they considered children to be at risk.
- Vulnerable patients were assigned a named GP who could liaise consistently with multidisciplinary colleagues for shared learning and care planning.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for this population group.

The practice is rated as requires improvement for the safe, effective, and well led domains, and good for responsive and caring. The concerns which led to these ratings apply to everyone using this practice, including this population group.

Summary of findings

- The provider was registered to provide enhanced services for patients with dementia and learning disabilities. As part of this status, the practice nurse attended annual specialist updates with the local authority on the care and treatment of patients with dementia.
- GPs offered assessments and provided specialist referrals for people with learning disabilities or depression. Mental capacity screening was completed using established best practice tools, including the 6-item Cognitive Impairment Test (6CIT) and the patient health questionnaire PHQ-9 depression screening tool.
- Staff could refer to a community crisis team, a memory clinic, counselling service and THE Improving Access to Psychological Therapies (IAPT) programme.
- The senior partner conducted a two-cycle audit of care of people living with dementia on an annual basis. This included a check of care plans and reviews and contributed to consistent standards of care.
- A separate quiet waiting area was available for patients whose mental health made the general waiting area distressing or unpleasant. Longer appointments were available for patients who required more time to discuss their needs with a doctor or the practice nurse.
- The practice nurse offered regular clinics for people living with dementia and their family or carers. GPs were able to provide direct, rapid referrals to a local memory clinic and the practice nurse supported patients to engage with an active living scheme.

Summary of findings

What people who use the service say

The latest national GP patient survey results for this provider were published in September 2015. The results showed the practice was performing above local and national averages. 308 survey forms were distributed, which represented 7% of the patient list. 107 forms were returned, which represented a 35% return rate.

- 97% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 82% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 92% of patients described the overall experience of this GP practice as good compared to the national average of 85%).
- 83% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%).

As part of our inspection we asked for CQC comment cards to be made available to patients prior to our inspection. We received 25 comment cards which were all positive about the standard of care received. People commented positively on the level of dignity, compassion and understanding all staff they came into contact with showed them. People with long-term or complex conditions said they appreciated the level of individual care the GPs and practice nurse gave them.

We spoke with five patients during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable, committed and caring

Areas for improvement

Action the service MUST take to improve

- Implement fire safety training and fire drills for all staff.
- Review the security of the premises, to include restricted access to the treatment room and vaccines.
- Update staff training records and ensure all staff are trained appropriately to meet their responsibilities.
- Implement annual appraisals of each staff member and ensure they receive regular supervision commensurate with their role.
- Ensure accurate and up to date information is available to patients on how to make a complaint.

Action the service SHOULD take to improve

- Review staff support and retention practices, including evidencing that staff receive a thorough induction programme.
- Develop a patient participation group.
- Improve access to interpreter services.
- Improve the management of sharps collection bins
- Implement cleaning schedules for all areas of the practice

Improve access to the Business Continuity Plan by having a back up paper copy

Dr Chandra Khatri

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, who was assisted by a GP specialist advisor.

Background to Dr Chandra Khatri

Dr Chandra Khatri, The Surgery, High Street, Tyldesley M29 8AL delivers commissioned services under the Personal Medical Services (PMS) contract with two full time GPs, a part time GP and regularly has a trainee doctor. The practice is part of Wigan Borough CCG area. There is one male GP and one female GP. At the time of our inspection there was one partner present. The practice has a nurse, healthcare assistant, practice manager, five administrative staff and a housekeeper.

Patients pre-book appointments in advance and GPs ensure there are some embargoed slots each day in case of appointment cancellations. Waiting times for appointments are typically two days. Emergency appointments are available daily and GPs and the practice nurse can see patients without an appointment in emergency situations. The practice has a policy of accepting all paediatric emergency patients, regardless of available slots and capacity.

The practice had a list size of 4646 patients at the time of our inspection. Most patients were of working age, between 18 – 65 years old; 19% of patients were under 18 years old and 16% of patients were over 65 years old. The level of deprivation in the practice catchment area is slightly higher than the England average, in the fifth most deprived decile.

The practice is open between 9am - 1pm Monday to Friday; between 2.30pm – 8.45pm on Mondays and 2.30pm – 6.30pm Tuesdays, Thursdays and Fridays. Telephone booking lines open at 8am- 6.30pm Monday to Friday and remained open until the end of service, with the exception of 1 – 2.30pm daily. An out of hours service is available after 6.30pm Monday to Friday. The practice does not provide out of hours GP services and signposts patients to one of two local practices overnight and on weekends. There is also a walk-in centre nearby open from 7am to 9pm every day of the year.

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 March 2016.

During our visit we:

- Spoke with a range of staff including GPs, a trainee doctor, the practice nurse and three administration staff. We spoke with patients who used the service.

Detailed findings

- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- The practice manager and healthcare assistant were unavailable during the 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 were provided for specific groups of people and what good care looked 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).

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

Requires improvement

Are services safe?

Our findings

Safe track record

- The practice reported three significant events (SE) in the 12 months prior to our inspection. There was an effective system in place for reporting and recording significant events.
- The minutes of significant event analysis meetings indicated learning had taken place for some incidents resulting in change to practice. For example, staff were encouraged to challenge incorrect prescriptions received from hospitals regardless of the seniority of the prescribing doctor.

Learning and improvement from safety incidents

- The practice incident policy focused on empowering staff to report incidents and mistakes as part of a 'no blame' culture. Staff we spoke with told us this worked in practice and they felt able to report incidents and concerns.
- Staff discussed incidents and significant events at clinical meetings but it was not always evident that processes or working practices were changed from the learning from incident investigations. For example, an incident investigation had taken place after a patient's treatment had been affected when a locum doctor could not find an item of equipment. Other staff could not locate this either because although they knew it was always kept in the same place, there was no system to track equipment or daily checks to ensure staff returned equipment to its usual storage place. Although staff told us they now made sure equipment was returned to the same place, there was no equipment location list or protocol in place to ensure equipment availability and storage was standardised.

Reliable safety systems and processes including safeguarding

- There was a clear and robust chaperone policy in place. The policy was detailed and included guidance for staff to follow when a non-clinical chaperone was used as well as considerations of gender and sexual identity. Staff who acted as a chaperone had an up to date criminal background check.
- The practice safeguarding lead had recently left and a GP was in the final stages of taking up this post. As an interim measure, if staff had a safeguarding concern they were instructed to discuss this with the lead GP who would then liaise with the local safeguarding team or NHS England.
- Staff demonstrated a detailed knowledge of the principles of safeguarding, including safeguarding children. Administration staff told us they were empowered to raise safeguarding concerns they had whilst observing patients and relatives in the waiting area and could escalate these rapidly to clinical staff.
- GPs were trained in safeguarding adults level 3 and safeguarding children level 3. Safeguarding protocols were readily available to all staff, had been updated in the previous 12 months and reflected national best practice.
- Non-clinical staff had access to electronic safeguarding training although not all administrative staff had completed refresher updates at the time of our inspection. Staff told us the new practice manager had a plan in place to address this.
- The staff handbook included a clear whistleblowing policy, which staff told us they were aware of and in what circumstances they would use it. This policy was also available readily in the main office and included guidance for staff on the types of incident that could result in a whistleblowing concern.
- All non-clinical staff employed in the practice had a current, clear record from the Disclosure Barring Service (DBS) or had submitted an application and were awaiting their certificate. All staff who acted as a chaperone had a current DBS check.
- Medicine was stored in a locked cabinet in a dedicated treatment room, which met national best practice guidance. However, vaccines were stored in an unlocked fridge in the main treatment room, which was unlocked and was not continually monitored throughout our inspection. Staff told us patients were always escorted in this area of the building although we did not see this in practice.
- The GP partner and practice nurse monitored drug alerts from the Medicines and Healthcare products

Regulatory Agency, which were audited for compliance. When an alert was received, the practice nurse reviewed patient records and made arrangements for anyone affected.

- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The lead partner had established a prescription reduction policy for new patients who used hypnotic medication. This involved a one-to-one discussion with each patient, who was required to agree to a reduction in their use of the medication over an eight week period.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- A designated medicines management technician was in place, who monitored prescriptions, stock and compliance with storage requirements.
- Staff conducted a monthly check of emergency drugs stored on the premises. This included reconciliation of stock and a check of expiry dates. We found this had been completed consistently in the six months prior to our inspection.
- The practice nurse monitored NHS England patient group directives (PGDs), which we saw were up to date and had been signed off.
- We reviewed personnel files including those for clinical staff and found appropriate recruitment checks had been undertaken prior to employment.

Cleanliness and infection control

- Most of the public, office and treatment areas in the practice were visibly clean. However, the carpet in the waiting room was soiled and a steam cleaning schedule was not in place.
- The lead GP was the infection prevention and control lead but they had not provided any updates or training to staff as part of this role.
- The administrator acting as interim practice manager had begun to conduct weekly Legionella testing in the week prior to our inspection. This had not previously been completed.
- A poster demonstrating appropriate hand washing procedures in line with World Health Organisation guidance was displayed at each sink.
- The sharps bin in the treatment room was stored above floor level but had an open aperture and there was no signature or first use date on the label. This meant the use of sharps storage and disposal did not comply with the Department of Health management and disposal of healthcare waste guidelines.
- There was inconsistent documented evidence of infection control training for each member of staff and some induction records did not include details of infection control briefings.
- The lead GP audited infection control in the minor surgery clinic and in the 12 months prior to our inspection there had been no recorded incidents or lapses.
- Cleaning schedules for each area of the building were not routinely maintained and were available only for the equipment managed by the practice nurse.
- We saw reception staff did not always adhere to good infection control principles. For example, disposable gloves and antibacterial hand gel were available at the reception desk for use by administration staff when accepting clinical specimens from patients. On two occasions we saw staff did not use these items and handled specimen containers without gloves and did not disinfect their hands afterwards.

Equipment

- A resuscitation trolley was available, which included an automatic defibrillator and oxygen, with masks for adults and children. Staff completed and documented monthly checks on the equipment and were trained in the use of the automatic defibrillator to Resuscitation Council UK guidelines.

Requires improvement

Are services safe?

- Equipment was serviced annually, including testing and calibration.
- The interim manager was responsible for ensuring equipment was maintained and ready for use.

Monitoring safety and responding to risk

- Confidentiality and computer security policies were in place and adhered to by staff. The policies meant patient data was secured and risks relating to the accidental disclosure of personal details were minimised.
- The practice had an established zero tolerance policy for aggression and violence. We saw this had been used appropriately by looking at incident reports and outcomes, such as when a violent patient was removed from the practice list. Staff told us this policy worked in theory but they had not received formal conflict awareness of de-escalation training to help them deal with aggression.

Arrangements to deal with emergencies and major incidents

- The practice had a major incident and business continuity policy in place.. Staff knew how to access this plan but said it was only stored electronically, with no hard copy back-up. This meant if there was a power failure, staff would not be able to access it as the computer system did not have a secondary power supply.
- The practice had an emergency mobile telephone available for the designated major incident lead in the event of an emergency or catastrophic failure of the building, equipment or power supply. A named person was required to check the emergency telephone on a daily basis for power and availability.
- The last documented fire alarm test had been carried out in November 2015. However, regular fire drills or practices with staff had not been completed and there was no evacuation plan in place. Staff had not received practical fire simulation training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs, they were responsible for maintaining their own knowledge.
- The practice demonstrated they carried out some monitoring to ensure these guidelines were followed through risk assessments, audits and random sample checks of patient records. For example an audit of children's records and diabetes care.
- The practice nurse had completed a review of all clinical protocols using NICE guidelines. The CCG also disseminated changes in practice guidance through the nurse.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available with 10% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators were better than the national average in all indicators. The practice performed better than the national average in the number of patients with diabetes who had a flu vaccine, at 98% compared to 94%.
- Performance for mental health related indicators was similar to or better than the national average in all four indicators. This included 100% of patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan and a recorded check of their alcohol consumption.
- There was evidence of quality improvement including clinical audit.
- There had been six clinical audits completed in the last two years, all of which were completed audits where the improvements made were implemented and monitored. Audits included medicines management, including drugs for weight management.
- The practice participated in national benchmarking, accreditation, peer review and research. For example, the practice contributed to the National Cancer Intelligence Network partnership. The practice met the England average for screening rates in four out of five categories. The exception was screening for breast cancer amongst women aged 50-70, whereby uptake within six months of an invitation was 44%, compared to an England average of 82%. The practice nurse was actively working to improve this outcome.
- Findings were used by the practice to improve services. For example, recent action taken as a result included a more conservative prescribing programme and protocol for patients on certain prescription medicines.

Information about patients' outcomes was used to make improvements such as:

- An audit of the prescribing of hypnotic drugs in February 2016 found they were being overprescribed. This resulted in new prescribing guidance for clinical staff in line with local formulary guidance.
- The practice nurse was responsible for contacting patients affected by changes as a result of medicine alerts. This was an effective system, which we saw evidence of from looking at patients affected by a change in the prescription of prostate cancer drugs.
- The practice nurse worked with local specialists including an angina nurse and a heart specialist to ensure they provided up to date treatment and care for patients. They had also taken blood results and values training from a local laboratory to ensure they worked to best practice guidance.
- The lead GP had undertaken a clinical audit of stroke prevention in atrial fibrillation therapy to supplement QOF reporting in January 2016. This audit measured practice care and treatment against NICE clinical guidance (CG180) on the management of atrial fibrillation. The audit found an additional 16% of

Requires improvement

Are services effective?

(for example, treatment is effective)

patients could benefit from anticoagulant treatment in line with CG180, which staff rectified following the audit. This resulted in 100% compliance with QOF outcomes. The lead GP offered a minor surgery clinic in line with their registration and NICE guidance. Audits were conducted on minor surgery for consent forms and for the completion of histology samples for skin lesions. In the 82 procedures audited between April 2015 and February 2016, all patients had completed consent forms in their medical records and all histology results were recorded. This helped to embed ongoing good practice.

Effective staffing

Staff had the skills and knowledge to deliver effective care but this was not always monitored or updated in a timely manner:

- An induction checklist was used to record when each member of staff completed an orientation of the practice and its policies. In the records we looked at, not all of the induction checklists were signed or dated. Some members of staff had an induction programme record but this was not always completed.
- A recruitment policy was in place, which included a structured induction process for staff. Poor staff retention and high levels of sickness had impacted working conditions and levels of responsibility. Existing staff were expected to increase their workload and responsibilities with no additional support or resources. Staff numbers on each shift were adequate but staff worked increasing hours to cover this.
- The practice accepted junior doctors under training. Junior doctors were well supported by GPs, who maintained a protected 30 minute slot each day to provide one-to-one supervision and support
- Staff were not consistently offered one-to-one performance supervision or appraisals. Practice staff told us this was due to the problems related to a period of time without a practice manager and the absence of the new manager. One member of staff had received an appraisal 13 months prior to our inspection. Another member of staff had an appraisal action plan in their file but this was undated. The member of staff recorded a request for additional training, which would help them with the administration of new patients. There was no evidence this had been acted upon. The practice nurse last received an appraisal in 2006. The practice did not have a system in place to ensure the nurse was appropriately supported or offered opportunities for development.
- Some staff we spoke with described the provision of in-house training as "poor" because there was a lack of consistency in how this was managed as a result of changes in the practice manager post.
- A member of the administrative team assisted the lead GP in the preparation of the treatment room for minor surgery. This included preparing needles and swabs and cleaning the room after each procedure. This member of staff had not received adequate infection control or patient safety training, such as basic life support. Although the lead GP had provided initial instruction, this did not ensure the member of staff had been assessed for competence in this role.
- Some staff training records were out of date, with no documented evidence to demonstrate training undertaken. The practice nurse managed their own training and professional development and this was up to date.
- The healthcare assistant had completed specialist skills training in line with their responsibilities as well as in mental health recovery and learning disability awareness.

Working with colleagues and other services

- Staff did not regularly facilitate multidisciplinary meetings with district nursing teams but GPs attended a six-weekly integrated care meetings. This was used to discuss people who frequently attended local accident and emergency hospital units and to identify strategies to reduce unnecessary attendances by meeting care needs locally.
- The practice nurse was the locality lead nurse and attended monthly practice nurse forums and education events with other GP practice nurses in the area.

Information sharing

- Clinical staff received test results through an electronic GP information system. This system was organised so

the most appropriate member of staff received the results. For example, test results relating to chronic disease management such as smear tests, were received directly by the practice nurse.

- The practice nurse recorded each smear test and made direct referrals to a colposcopy service. This member of staff maintained a record of follow-ups and test results, which meant patients received a seamless service when they returned to the practice.
- The doctor on call was responsible for reviewing discharge letters and individual GPs were responsible for specialist referrals. The practice nurse was able to make direct referrals if a patient had already been seen by the specialist. This reduced the time it took for patients to see a specialist.

Consent to care and treatment

- Links had been established with the local community learning disability (LD) team and the practice nurse engaged with them to make sure services met the needs of patients. This member of staff demonstrated excellent knowledge of the needs of LD patients in relation to consent. For example, to support a patient with an LD who needed a specialist test; the nurse explained what the test was for and why they needed it by using pictures and visual aids. The nurse secured a member of the LD team to accompany the patient to the test clinic and made sure they received one-to-one guidance at each stage of the process.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting people to live healthier lives

- The practice nurse provided health promotion support to patients, including harm reduction in relation to smoking, drinking and diet. This individual had built effective relationships with many patients by providing consistent, long-term support and information. For example, they had worked closely with patients at risk of long-term health complications due to poor diet to reduce their cholesterol and fat intake.
- GPs opportunistically offered health promotion signposting to patients, such as to sexual health services. However, there was no information in waiting areas for patients on sexual health, including for young people.
- A weekly baby clinic was offered where new parents were offered health promotion support, such as how to keep a baby cool.
- A healthcare assistant conducted new patient health checks, including specific checks for patients over 40 years old and over 74 years old. Health checks included the identification of cardiovascular and diabetes risks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The latest available GP Patient Survey data was published in January 2016. In this survey 16% of patients were invited to participate and the response rate was 35%, with an overall positive experience recorded by 92% of people.

Respect, dignity, compassion and empathy

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.
- Staff had an awareness of the need for patient confidentiality and told us one of the challenges they faced was due to a small local population where a lot of their registered patients knew each other. To mitigate this, patients were offered electronic check-in for appointments as well as the opportunity to speak privately to administration staff on arrival.
- A remote language interpreter service was available but some clinical staff told us the process was lengthy and could cause delays. There was not an effective alternative to this and one member of staff said they would try and encourage a patient to return with a family member or friend who could interpret for them. This was not an appropriate strategy as it did not consider potential safeguarding issues that could arise from asking someone with a personal relationship to the patient to translate for them.
- **Care planning and involvement in decisions about care and treatment**

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

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.
- Patients were involved in discussions about their use of certain medications, including antibiotics, benzodiazepines and hypnotics. This was supplemented by a 'When should I worry?' leaflet, which helped people to understand the correct uses of different drugs.
- As part of the practice long term plan to reduce patient need for hypnotic medicines, sleep diaries were issued for to patients for use in the first two weeks of their drug reduction programme. This was supplemented with a discussion on the long-term risks of hypnotics use, such as the risk of falls and dementia. This helped patients to agree to a gradual reduction in their dose of hypnotic medicines.

Patient/carer support to cope emotionally with care and treatment

- GPs were trained to provide palliative care and support to patients and their relatives and followed the Gold Standards Framework for this. Mortality reviews did not always take place and were undertaken sporadically by GPs.

Good

Are services caring?

- Clinical staff made telephone contact with family members following a patient death, offered a referral to a local counselling service and offered a one-to-one discussion.
- Patient waiting areas contained printed information for carers on how they could access community support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- Administrative staff managed their own allocated chronic disease register based on specialist needs, such as depression and mental health. This meant patients were monitored efficiently and reduced the risk of delayed or missed regular check-ups. The system had resulted in improved call and recall of patients. This system was vulnerable to staff absences however and recent absence in the administration team meant that other staff had used opportunistic invitations to patients with hypertension for check-ups.
- The administration team had also been trained to add prompts to prescriptions, such as for a blood pressure check or a referral to the smoking cessation clinic.
- The practice had proactively developed its procedures to care for people prescribed antipsychotic or hypnotic medication and for diabetes control.
- Reducing the need for antibiotics was a priority established by the lead GP partner.
- The lead GP partner offered a minor surgeries clinic, which included provision for joint injections, management of intrauterine contraceptive devices, coil removal and implant removal.
- An access ramp was in place from the street to the waiting room and a lift was available for patients and visitors who used a wheelchair, who had reduced mobility and for pushchairs. An accessible toilet was available on the ground floor of the building however baby changing facilities were not available.
- A quiet waiting area was available for use by patients who would otherwise experience anxiety in the main waiting area.
- Printed and posted information in waiting areas included cancer diagnosis and treatment, allergies, terminal illness, cholesterol, memory loss, shingles, hearing loss and signposting for men when they found blood in their urine.
- We received feedback from people who used the service and completed comment cards about how responsive the service was. In all cases people gave positive feedback about the permanent GP and nurse team, however some said the number of locum doctors used sometimes meant they felt the service was sometimes inconsistent.

Tackling inequity and promoting equality

- The electronic patient check-in system included options for assistance in multiple languages, including the languages most commonly spoken in the local community by staff.
- The chaperone policy included consideration of gender and sexual identity and provided support for staff to ensure a chaperone was allocated appropriately.

Access to the service

The practice was open 9am – 1pm Monday to Friday; between 2.30pm to 8.45.pm on Mondays and 2.30pm to 6.30pm Tuesdays, Thursdays and Fridays. Telephone booking lines opened at 8am Monday to Friday and remained open till 6.30pm, with the exception of 1pm – 2.30pm daily. Urgent appointments were available for people that needed them. An out of hours service was available after 6.30pm Monday to Friday.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment:

- 82% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 97% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 82% of patients said the last time they wanted to see or speak to a GP or nurse they were able to get an appointment. People told us on the day of the inspection that they were able to get appointments when they needed them. Some people commented in their feedback about the automated phone message system used in the practice. They told us although the practice advertised it accepted calls from 8am each weekday, the phone line was often still unavailable at 8.15am.
- 90% of patients said the experience of making their last appointment was good, compared to 73% nationally. 65% felt they did not wait too long to be seen,

Good

Are services responsive to people's needs?

(for example, to feedback?)

compared to 58% nationally and 76% said they usually waited 15 minutes or less after their appointment time to be seen. This was better than the national average of 65%.

- The practice nurse offered open clinics from 9am – 1pm on Monday and Friday and from 9am to 6pm on Wednesday.
- Administrative staff triaged telephone requests for home visits and the urgency of such requests was decided by the GP on-call.

Listening and learning from concerns and complaints

- The practice had a system in place for handling complaints and concerns.
- In 2014/15, the practice received a total of six formal written complaints. Two related to communication or staff attitudes, three related to clinical elements of the service and one related to management. None of the complaints were upheld following investigation.
- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England but was not displayed in any area of the practice.
- There was a designated responsible person who handled all complaints in the practice.
- Complaints were investigated by an appropriate individual and we saw evidence improvements had been implemented as a result. For example, new reception staff were given a more detailed induction to help them provide additional services to patients, such as the provision of identity checks for local authority forms.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

- Staff were very proud of the services offered by the practice and these had been maintained despite the ongoing staffing problems. However, there was no established vision for service development, sustainability or improvement, other than to continue as they were doing.

Governance arrangements.

- Overall governance and management oversight arrangements were not consistently effective, evidencedby the lack of consistent staff appraisals and management of medicine security.
- Administrative staff had undertaken recent training in a number of areas of importance to governance, including information governance; password management; control of access to health records; patient confidentiality; secure transfer of patient data; information security; records management and the NHS Code of Practice.
- There was a risk to patient data as the computer system did not require smart cards to gain access and the practice nurse's room did not lock.
- Information to patients about how to complain was not readily available within the practice or on the practices web site.The web site referred to the Primary Care Trust details which had not been in operation for several years.
- All practice staff attended a monthly meeting to discuss incidents, complaints, new starters and any other issues that would affect their work or patient experience. After this, clinical staff attended a sub-meeting to discuss clinical events or protocol changes. Staff told us they could influence meeting agendas and felt issues were discussed and actioned appropriately.
- Clinical and administration protocols were available on each computer and staff could access these readily. The practice nurse and an administrator in place of the practice manager took responsibility for updating policies. However, most of this took place outside of paid work time. For example, the practice nurse was allocated 30 minutes of administration time per week, which was not adequate for them to complete accurate policy updates

Leadership, openness and transparency

- Staff said the lead GP partner was understanding and supportive of the shortfall in administration staffing although there was no formal plan or strategy to address this.
- The practice planned to hold monthly staff meetings to discuss significant events, complaints and incidents. Some staff told us the meetings did not take place consistently due to staff shortages.
- One member of staff told us everyone respected each other and worked well together but there was no visible management structure in place. They said that it was a positive team to be part of in spite of problems and that everyone had pulled together.

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

- A Patient Participation Group (PPG) was not in place at the time of our inspection and the lead GP told us this was due to low levels of interest from patients. There was a poster in the waiting room advising interested patients to speak to a receptionist.
- A suggestions box and feedback questionnaire was available in the waiting room.
- The leadership team had not always acted on feedback or requests for support from staff. For example, one member of staff had documented in a supervision meeting they were struggling to manage their daily level of work. There was no record a manager had followed this up or provided appropriate support.
- Staff told us they could approach the lead GP with suggestions and they felt these would be considered and acted upon if possible. For example, the practice nurse was able to suggest the provision of new diabetic agents for some patients, which the lead GP considered based on the patient's condition and need.

Are services well-led?

Requires improvement

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

- The practice nurse was able to add patients to the GPs' appointment list at any time if they were concerned about their condition. This ensured patient risk was managed and demonstrated a productive working relationship between clinical staff.
- Staff were not formally involved in looking at patient feedback and told us they often looked informally at online feedback through the NHS Choices service.

Management lead through learning and improvement

- The practice nurse supported GPs to take swab samples from patients, which had resulted from a process of service improvement to ensure patient delays were minimised.
- The healthcare assistant had completed a programme of work focused on patient care plans to reduce the need for the most high-risk vulnerable 2% of patients to be admitted to hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Access to the treatment room was unsecured and unmonitored. This included access to an unlocked fridge used to store liquid vaccines.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Fire safety in the practice was inadequate as staff did not conduct regular fire drills or fire training. There was no evidence fire safety had been assessed and staff did not have an awareness of a coherent evacuation plan. Information for patients on how to make a complaint was not easily accessible.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received continuous supervision, appraisal and appropriate training to perform their role safely or adequately. This included a practice nurse who had not received annual appraisals and a member of the administration team who supported minor surgery without appropriate training. Not all staff had appropriate infection control training.