

Dr Samuel Bhasme

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
What people who use the service say	6
Areas for improvement	6

Detailed findings from this inspection

Our inspection team	7
Background to Dr Samuel Bhasme	7
Why we carried out this inspection	7
How we carried out this inspection	7
Detailed findings	9
Action we have told the provider to take	20

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Samuel Bhasme on 02 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring and responsive services and was well led. The practice requires improvement with regard to safe practices. It was also good for providing services for older people, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia)

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, but no analysis had been carried out. The practice could not demonstrate that any learning had occurred from significant events and incidents.
- 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 said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients were able to book routine appointments with the GP at a time that suited them. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on. Some audits had been carried out; we saw little evidence that audits were driving improvement in performance to improve patient outcomes.

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

Summary of findings

Importantly the provider must:

- Ensure that staff carry out analysis of incidents, significant events and near misses
- Ensure audits of practice are undertaken, including completed clinical audit cycles to improve standards of care and reduce risk.

- Ensure that the lead for safeguarding obtains the correct level of training for the role (level 3)

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?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The practice could not demonstrate that lessons were learned or communicated to support improvement. Information about safety was recorded. However significant events and incidents were not monitored, reviewed and appropriately addressed. Risks to patients were assessed and managed. There were enough staff to keep people safe, but staff had not received the appropriate level of training with regard to safeguarding.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Multidisciplinary working was taking place but was generally informal and record keeping was limited.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England area team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Good



Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

The practice is rated as good for well-led. The practice had a vision and a strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems to monitor and improve quality and identify risk. Although some audits had been carried out, we saw little evidence that audits were driving improvement in performance to improve patient outcomes. The practice sought feedback from staff and patients and this had been acted upon. The practice had a patient participation group (PPG) although meetings had not been as frequent recently. Staff had received inductions and regular performance reviews.

Good



Summary of findings

What people who use the service say

We spoke with five patients. We received 2 completed comment cards.

Both patients who commented were pleased with the quality of the care they had received. The themes running through the comment cards and the patient interviews were that the staff were very kind and considerate. Patients commented on how referrals were made quickly and with the patients' involvement

There is a survey of GP practices carried out on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 369 survey forms were sent out and 114 were returned. The main results from that survey were:

- Patients said that they usually wait 15 minutes or less after their appointment time to be seen and the practice had a higher score than the local CCG average of 84%
- Patients said that the GP they saw or spoke to was good at involving them in decisions about their care and the practice had a higher score than the local CCG average of 83%
- Patients reported that the experience of making an appointment was not so good and the practice scored lower than the CCG average at 73%
- Patients said that their overall experience of the practice was good
- 70% of patients indicated that they would recommend the practice to others which was in line with the national average.

Areas for improvement

Action the service MUST take to improve

- Ensure that staff are aware of incidents, near misses and concerns that arise and that learning takes place to reduce the risk of reoccurrence.
- Ensure audits of practice are undertaken, including completed clinical audit cycles.
- Ensure that the lead for safeguarding obtains the correct level of training for the role (level 3)

Dr Samuel Bhasme

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Samuel Bhasme

Dr Samuel Bhasme practices from Railway Street Surgery located in Gillingham Kent. The practice provides care for approximately 2865 patients. The practice has a higher than the national average percentage of patients over 65 years. The number of people in the area who are unemployed is higher than the national average.

There is one GP, male. The practice provides 13 GP sessions each week, one session being half a day. There is one female practice nurse who provides 6 sessions each week. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a training practice.

Services are delivered from:

The Surgery

19 Railway Street

Gillingham

Kent

ME7 1XF

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care through the NHS 111 service.

The CQC intelligent monitoring placed the practice in band 1. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data,

Detailed findings

results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 02 December 2014. During our visit we spoke with a range of staff including a GP, nursing staff, receptionists and administrators. We spoke with patients who used the service.

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

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

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

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

Are services safe?

Our findings

The practice used a range of information to identify risk and improve quality regarding patient safety. For example they considered reported incidents and accidents, national patient safety alerts as well as comments and complaints received. This was a small practice and staff we spoke with felt confident that they could raise any safety issues with the GP and nursing staff. The staff were aware of their responsibilities to raise concerns and knew how to report incidents or near misses. However there was no significant event policy. The practice could not demonstrate that lessons were learned or communicated to support improvement. Information about safety was recorded. However significant events and incidents were not monitored, reviewed and appropriately addressed.

We reviewed safety records, four incident reports and minutes of meetings for the last year which showed that the incidents were not routinely discussed or any learning was gained from them. This showed the practice had not managed these consistently over time and so could not show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system for reporting and recording significant events, incidents and accidents but did not monitor them. There were records of significant events that had occurred during the last year and we were able to review these. Significant events had not been recorded for discussion on the practice meeting agenda. The meeting minutes we examined contained limited information and did not contain details about any of the significant events we reviewed. Staff informed us that practice meetings were held monthly and we saw records of these. There was little evidence that the practice had learned from significant events or that the findings were shared with relevant staff.

Staff used incident forms and sent the completed forms to the GP. We looked at the system used to manage and monitor incidents. We tracked four incidents and saw records were not always completed in a comprehensive and timely manner.

National patient safety alerts were disseminated by informal discussion to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also

told us alerts were discussed as and when they arose during daily informal meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed the GP as the lead in safeguarding vulnerable adults and children. Records confirmed they had not completed the necessary training to enable them to fulfil this role (Level 3). The staff had completed appropriate levels of safeguarding training, level 2 for nurses and Level 1 for administration staff. All staff we spoke with were aware of who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

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 a safeguard and witness for a patient and health care professional during a medical examination or procedure). Only nursing staff acted as chaperones where requested.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

Are services safe?

and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

The practice had a process to check emergency medicines and vaccines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked two anonymised patient records which confirmed that the procedure was being followed.

All prescriptions were reviewed and signed by the GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The premises appeared to be clean and tidy. We saw there were cleaning schedules and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

All staff had received infection control training within the last year. We looked at the last infection control audit which was carried out in November 2014. The audit had identified that only hepatitis B vaccinated staff are to transport clinical waste to the dedicated waste bin. Staff confirmed that only the nurses and health care assistant emptied the clinical waste bins. Staff files confirmed nurses and health care assistants were vaccinated.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use

and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

Equipment

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

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system to ensure that enough staff were on duty. There was also an arrangement for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to

Are services safe?

the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support and this training had been completed within the last year. Emergency equipment was available including access to medical oxygen. When we asked members of staff, they all knew the location of this equipment. We observed records to confirm that it was checked regularly.

Emergency medicines were 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. The practice had a process 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.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. Staff told us that they had a reciprocal arrangement with another GP practice in close proximity for continuity of care. The document also contained relevant contact details for staff to refer to. For example, contact details of an information technology company to contact if the computer system failed. We saw records that demonstrated the plan had been followed when the computer system failed.

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

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GP told us they lead in specialist clinical areas such as diabetes, heart disease, sexual health screening and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients who were on particular medicines for pain relief which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within one week by their GP according to need.

The GP we spoke with used national standards for the referral of patients with suspected cancers who were referred and seen within two weeks.

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

Management, monitoring and improving outcomes for people

The practice showed us two clinical audits that had been undertaken in the last year. One of these was complete. The practice was able to demonstrate the changes resulting since the initial audit. Other examples included audits which looked at patients in receipt of oral nutritional supplements. There was no clear standard of measurement, findings, or how this would improve clinical service. Staff told us the practice needed to carry out further work in this area.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of medicines used in the treatment of arthritis. Following the audit, the GP had carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice identified its frequent A&E attendees. In some cases reviews and treatment avoided patients re attending, in other cases attendance was unavoidable such as injury or complex medical history.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice scored below average for its ability to diagnose the common long term conditions that were assessed by QOF such as diabetes and asthma. In this regard the practice had improved its own performance over the last few years and was marginally below the local and national averages. We looked at nine clinical areas. In all of them the incidence of diagnosis of the condition had improved. We found that there had been treatments carried out, such as foot examinations for diabetic patients. This had not always been coded correctly and therefore did not contribute to the final QOF scores for 2014.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this, staff regularly checked that patients receiving repeat

Are services effective?

(for example, treatment is effective)

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

Effective staffing

Practice staffing included medical, nursing, and administrative staff. We reviewed staff training records and noted that not all of the staff were up to date with courses such as safeguarding and had not completed the required level for their role. Other mandatory training was up to date including annual basic life support. The GP was not up to date with their yearly continuing professional development requirements and was due for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided training and funding for relevant courses.

The practice nurse performed defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, and cervical cytology. The nurse carried out extended roles in seeing patients with long-term conditions such as asthma, COPD, diabetes, sexual health screening and coronary heart disease, and was also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy

outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had a process to follow up patients discharged from hospital. We saw that the policy for following up hospital communications was working well in this respect.

The practice held quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice had an electronic system for making referrals, and the practice made most referrals where appropriate through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their

Are services effective?

(for example, treatment is effective)

practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The GP used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that

51% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all had been offered an annual physical health check. Practice records showed 99% had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered a referral to the local smoking cessation clinic to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 67% which was lower than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. There was also a member of staff responsible for following up patients who did not attend screening.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available from the national patient survey. This showed that patients felt they were treated with dignity and respect. Patients said that the GP and nurse listened to them, explained tests and results and treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed cards and both were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients commented on how they liked to always see the same GP. That they did not have to explain past problems and that the GP knew them well.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that this information was kept confidential. The practice telephones were located away from the reception desk and shielded by a glass partition which helped keep patient information private. The reception was located away from the waiting area to reduce conversations being overheard. We saw this system in operation during our inspection and noted that some conversations were audible and that there was a risk that sensitive information could be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the GP. This would then be investigated.

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

Care planning and involvement in decisions about care and treatment

Patients said that the GP and nurse discussed their health with them and they felt involved in decision making about the care and treatment they chose to receive. For example we saw that all 21 mental health patients had a care plan which had been discussed and agreed with them. Patients said that staff explained the care and treatment that was being provided and what options were available. Patients also received appropriate information and support regarding their care or treatment through a range of informative leaflets. The patient record system used by the practice enabled the GP to print out relevant information for the patient at the time of the consultation.

Patients' comment cards and the patients we spoke with reported that they felt listened to. They felt the care was very good. They said that they were treated as individuals by staff who knew them well. Several patients commented on how quickly problems and referrals were acted on. We saw the process that was followed when a patient was referred to a secondary provider. Once the patient and GP had made the decision staff discussed with the patient where they wanted to have the treatment or consultation and made the arrangements, there and then, with the patient using the Choose and Book system. The patient left the practice with all the arrangements complete and merely needed to confirm them with the receiving hospital or provider.

Staff told us that translation services were available for patients and the practice had a higher than the local average percentage of patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

Comment cards we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example one patient shared with us their recent experience of bereavement and how the practice was supporting the whole family through a difficult time. The patients we

Are services caring?

spoke with on the day of our inspection and the comment cards we received were consistent with how staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said the GP went out of his way to help them, by always being on hand to visit them or offer advice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This included making the waiting area more children friendly. As a result, the practice had purchased cleanable toys for children to play with whilst waiting. The practice cleaner demonstrated how the toys were cleaned regularly.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to online and telephone translation services and the GP spoke a number of Indian dialects.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. Staff files we examined confirmed this

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was easily accessible with no steps. Patients would also have the option of a home visit if they preferred where mobility was a problem.

The practice was situated on the first floor of the building with all services for patients on the first floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Appointments were available from 8.30am to 12 noon and 2pm to 6pm on Mondays and Tuesdays, Thursdays and Friday and half-day on Wednesdays from 8am to 12pm.

Between 12pm and 2pm patients were directed to the out of hours service. Staff told us that home visits would be made as well as visits to local care homes between the hours of 12 noon and 2pm on Mondays and Thursdays. As the practice also open between 6.30pm and 8pm on Tuesdays, patients could attend after working hours. The practice also held a walk in clinic for children between 1.30pm and 2.30pm Tuesdays and Fridays with no appointments necessary.

Comprehensive information was available to patients about appointments in a practice leaflet. This included how to arrange routine appointments, urgent appointments and home visits. There were arrangements to help ensure patients received urgent medical assistance when the practice was closed. When patients telephoned the practice when it was closed, there was an answerphone message giving the contact details of the out of hour's provider.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with the GP or nurse. Home visits were made to a local care homes when required by the GP and to those patients who had requested a home visit.

Patients were generally satisfied with the appointments system. However, comments on NHS Choices were less positive with regard to obtaining an appointment. There was a recurring theme that patients had difficulty getting through in the thirty minute time frame from 8.30am to 9am to be told that the entire book on the day appointments had gone and to call back the next day. When they did manage to book an appointment they said they could see a doctor and told us they liked the fact they always saw the same doctor. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system such as posters in the

Are services responsive to people's needs? (for example, to feedback?)

waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the only complaint received in the last 12 months and found it had been satisfactorily handled and dealt with in a timely way. The complaint was still ongoing.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. All staff was aware of the plan. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients.

Governance arrangements

The practice had a number of policies and procedures to govern activity and these were available to staff. We looked at seven of these policies and procedures. All seven policies and procedures we looked at had been reviewed annually and were up to date.

There was a range of mechanisms to manage governance of the practice. There were regular meetings between staff at lunch time each day when the practice was closed to patients. There were no minutes of these but we were told that at these meetings day to day problems were resolved informally and staff was able to give examples of how these discussions had benefitted individual patients and kept their own clinical practice under review.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. QOF data was regularly discussed at informal daily meetings.

The practice did have a programme of clinical audits to monitor quality and systems. There had been some clinical audits carried out and all but one had not been completed.

The practice had carried out risk assessments with regard to fire safety, the building environment and disabled access.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and comments about the practice. Receptionists we spoke with said that they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we spoke with said they felt valued by the

practice and able to contribute to the systems that delivered patient care. All the staff had responsibility for different activities, for example, for checking on QOF performance.

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

The practice had gathered feedback from patients through patient surveys and their patient participation group. The overall consensus was that the patients who participated were happy with the services they had received. The survey had identified that it was often difficult to get an appointment in the thirty minute timeframe each day between 8.30am and 9am to obtain a “book on the day appointment”. Staffs were discussing ways to improve this.

The practice is forming a PPG and one person has expressed a willingness to participate and a meeting is arranged to involve others. The practice had found it difficult to recruit other patients despite a drive to do so. Some patients had expressed an interest in joining the PPG and the practice was arranging a meeting to include them

Staff we spoke with felt that the practice was open to suggestions from staff. They said that they were made aware of comments and complaints through the daily meetings that were held and through internal emails. It was though patient suggestions that the practice had installed a security light in the alleyway beside the practice. Patients had commented that during the winter months it was very dark when they used the alleyway to access the practice.

The practice had a whistleblowing policy which was available to all staff in the staff handbook.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. There was a record of the training issues that had come up in staff appraisals and there were plans to address them.

The practice had not completed reviews of significant events and other incidents or shared the findings with staff to ensure the practice improved outcomes for patients. The staff were aware of the need to improve standards in this area.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers 1 (a) (c) (i) How the regulation was not being met: The registered person did not carry out analysis of incidents, significant events and near misses or complete audit cycles to improve standards of care and reduce risk.
Family planning services	
Maternity and midwifery services	
Treatment of disease, disorder or injury	