Dr Narendra Patel

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr. Narendra Patel practice on 14 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing a safe, well-led, effective, responsive and caring service. It was also rated as good for providing services for all population groups.

Our key findings were as follows;

- 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 was provided to help patients understand the care available to them.
- The appointment system was sensitive to the needs of the population groups and offered extended hours every Monday from 6.30pm to 7.30pm.
- All staff understood their responsibilities in raising concerns and reporting incidents and near misses.
- The practice linked with the Clinical Commissioning Group and other local providers to enhance services and share best practice.
- Complaints were sensitively handled and patients are kept informed of the outcome of their comments and complaints
- The practice had a clear vision which had quality and safety as its top priority.

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

Importantly the provider should:

- Complete an appropriate Legionella risk assessment.
- Ensure there is a completed fire risk assessment which is acted upon.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Although risks to patients who used services were assessed, some systems and processes to address these risks need to be assessed and updated. For example the practice did not have a completed fire risk assessment. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to ensure all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines. The practice was using pro-active methods to improve patient outcomes and linked with other local practices to share best practice. Consent to treatment was always obtained where required and this was confirmed to us when we spoke with patients. The practice regularly met with other health professionals and commissioners in the local area to review local quality initiatives. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data from the national GP patient survey showed that patients rated the practice higher than the local CCG average for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services.

We found the practice had initiated positive service improvements for their patients. The practice reviewed the needs of their local

Summary of findings

population and engaged with NHS England and the Clinical Commissioning Group (CCG) to secure service improvements where possible. Appointments were available the same day including routine appointments in the majority of instances. This was evidenced via their appointments system, patients we spoke with and the CQC comment cards we received and also verified by staff. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with all staff.

Are services well-led?

Good

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

The practice effectively responded to change. There was a clear set of values which were understood by staff and demonstrated in their behaviours. The team used their clinical audits, information from surveys, the patient participation group (PPG) and staff meetings to assess how well they delivered the service and to make improvements where possible. The PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are taken into consideration and to work in partnership with the surgery to improve common understanding. There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued for the roles and responsibilities they undertook.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up any children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and all had received a follow-up. It offered longer appointments for patients with a learning disability.

The practice informed vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All patients experiencing poor mental health had received an annual physical health check. The practice GP ensured they were kept informed of any changes in the case management of patients experiencing poor mental health, including those with dementia. The practice carried out advanced care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and had literature they could make available to patients about voluntary organisations such as MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with two patients during the inspection and received 41 completed CQC comments cards. The patients we spoke with said they were very happy with the service they received. They told us they experienced no difficulties getting through to the practice by telephone, access to the service was excellent and they could gain an appointment the same day if required. The CQC comments cards highlighted that the practice and dispensary was highly valued by patients. Patients' comments were overwhelmingly positive in respect of the care, treatment and service provided by the GP. There were only positive comments made about the practice, staff, care treatment and service, many commenting that it was a first class practice.

Patients did not identify any problems specifically with confidentiality at the reception desk. Patients were aware they could ask to speak to the reception staff in another room if they wanted to speak in confidence with a receptionist.

Patients we spoke with told us they were aware of chaperones being available during intimate examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GP, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They were given printed information when this was appropriate.

Areas for improvement

Action the service SHOULD take to improve

Complete an appropriate Legionella risk assessment.

Ensure there is a completed fire risk assessment which is acted upon.

Dr Narendra Patel

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP.

Background to Dr Narendra Patel

Dr Narendra Patel practice is located in Betley, Wrinehill and is part of the NHS North Staffordshire Clinical Commissioning Group. The total patient population is 1837. The practice is in an area considered as one of the least deprived when compared nationally. The practice is a dispensing practice.

The staff team currently comprises of a male GP providing full time practice sessions. Working alongside the GP is a practice manager, two part time nurses, reception and dispensary qualified staff and reception/administration staff. There are 10 staff in total, including the GP and part time cleaner who are employed either full or part time hours.

Surgery opening times are between Monday to Friday 9am to 10.30am and 4pm and 5.30pm with the exception of Thursday afternoons when they are closed. A late surgery is available on Mondays between 6.30pm to 7.30pm. The practice does not provide an out-of-hour service to its own patients but has alternative arrangements for patients to be seen when the practice is closed, which included Thursday afternoons.

Why we carried out this inspection

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

We carried out 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.

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.

How we carried out this inspection

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

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

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

Detailed findings

• 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),

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew.

We carried out an announced visit on 14 January 2015.

During our inspection we spoke with a range of staff including the GP, the practice manager, nurses, and reception dispensary staff. We spoke with two patients and observed how patients were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

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

The practice had an effective system in place for reporting, recording and reviewing significant events. Records were kept of significant events that had occurred during the last 12 months and these were made available to us.

The practice manager was aware of their responsibilities to notify the Care Quality Commission about certain events. For example, if there was an occurrence that would seriously reduce the practice's ability to provide care. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts, comments and complaints received from patients.

Learning and improvement from safety incidents

We looked at how lessons learned from significant events were extracted and shared with staff. The GP informed us that they decided which staff groups required the specific learning information from the significant events, incidents, accidents or complaints. They informed us this was to ensure timely targeted learning and development. They considered widening the learning and sharing to the whole staff team where it was appropriate to do so. This helped ensure the practice maintained a regime of continuous improvement. An example included an interrupted electricity supply to the practice vaccine fridge. The fridge was moved, advice was taken in respect of the vaccines and electricians investigated the root cause of the interrupted electricity supply. Practice staff were aware of the event, action was taken immediately and any learning shared with all staff.

We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GP and clinical staff and action taken as required.

Reliable safety systems and processes including safeguarding

The practice had policies in place in relation to safeguarding vulnerable adults and children. These were readily accessible to staff on the practice intranet and in paper copies. Staff we spoke with confirmed their awareness of them. There was also access to local authority contact names and numbers. The GP acted as the adult and children's safeguarding lead for the practice and a designated nurse took on the responsibility of deputy lead.

Systems were in place to highlight vulnerable patients on the practice's electronic records. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities (LD).

We saw that all clinical staff members had completed safeguarding children training to level 3. Non-clinical staff completed level 1 training which was up to date and all staff were aware of how to recognise and safely report any safeguarding concerns.

The practice advised patients they could have a chaperone present during their consultation if they wished. We saw that staff could access the practice chaperone policy. When a chaperone was requested the role was ordinarily fulfilled by nurses but all staff had received chaperone training.

Medicines management

Systems were in place for the management of medicines. Emergency medicines for cardiac arrest, anaphylaxis (shock) and hypoglycaemia (low blood sugar) were available within the practice. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. We saw other medicines stored within the practice were in date and robust systems to check expiry dates were implemented. Oxygen was available and stored appropriately. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

The medicine fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed. Vaccines were kept in a locked fridge. The fridge temperature was monitored twice daily. Staff were aware of the action to take if the temperature was not within the acceptable range. There was a clear cold chain protocol in place that followed NHS England's Protocol for Ordering,

Good

Are services safe?

Storing and Handling Vaccines March 2014. Patients could access travel vaccinations other than yellow fever at the practice and staff maintained appropriate records regarding patients in receipt of vaccines.

Medicine reviews were conducted by the GP. The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. The practice processed repeat prescriptions within 24 to 48 hours and in most cases prescriptions could be dispensed within five minutes of receipt of the prescription following an appointment with the GP. Patients' confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs. Security measures were in place for prescriptions access in line with suggested best practice within the NHS Protect Security of prescription forms guidance, August 2013.

The practice checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes.

The practice operated a dispensing service. Professional support was provided to the dispensary staff by the GP and the community pharmacist. Written policies and procedures describing medicines management at the practice in the form of standard operating procedures were in place to help ensure consistency in practice.

The dispensary had a controlled drugs register in place (this is for medicines which require extra administration checks to ensure safety) and regular audits of the controlled drugs took place. These were stored appropriately in a locked metal cabinet/safe with controlled access by the authorised key holder. The dispensary standard operating procedures included the safe disposal of medicines and appropriate record keeping such as the destruction of any controlled drugs.

The GP advised us that they took suitable precautions to prevent the loss or theft of their bag on home visits. If medicines were required they were carried in a locked carrying case and would not be left on view in a vehicle. Staff showed us that should a prescription be required for home visits the prescription serial numbers were recorded appropriately for audit purposes.

Cleanliness and infection control

Infection Prevention and Control (IPC) was monitored within the practice and the policy was available to all staff. This gave information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. There was an identified IPC lead who ensured all aspects of the policy were implemented fully. The lead had attended appropriate training to carry out her role. Infection control training was provided for all staff as part of their induction, and we saw evidence that the training was updated regularly.

The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated effectively. We observed the premises to be clean and tidy and saw facilities such as hand gels, paper towels, pedal bins, and hand washing instructions to encourage hygiene were displayed in the patient toilet. We saw there were hand washing facilities in the GP surgery, nurse's treatment room and dispensary, and instructions about hand hygiene were displayed. Protective equipment such as gloves and aprons were readily available. Curtains around examination couches were washable. There was a planned schedule for cleaning the curtains unless they became soiled in the interim period and they were then washed immediately. Examination couches were washable and were in good condition. Each clinical room had a sharps disposal bin. There was a record of when each bin started to be used.

A part time cleaner was employed and there was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. The practice was cleaned in line with infection control guidelines and staff informed us that should the need arise in the event of sickness then all the clinical staff took on the responsibility to ensure their rooms were cleaned in line with the cleaning schedule.

The IPC audit was conducted by the IPC lead and information following the audit was held on file with an action plan to address any areas requiring improvement.

There was no documented Legionella risk assessment completed by the practice. The GP informed us the practice had a low risk as they had no water storage systems in the practice and no water temperature checks had been completed. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

Good

Are services safe?

We found that literature to inform staff about the Control of Substances Hazardous to Health (COSHH) was available for staff to read. Cleaning products were stored in lockable cabinets in line with COSHH.

Equipment

Evidence was kept at the practice to confirm annual safety checks, such as for fire extinguishers had been completed. Portable electrical appliances and equipment calibration had been carried out by the practice. The computers in the reception and clinical rooms had a panic button system where staff could call for assistance if required. One of the panic buttons directly linked to the police station. Fire alarms and extinguishers were in place. Care and treatment was provided in an environment that was well maintained. Appropriate arrangements were in place with external contractors for maintenance of the equipment and building.

Staffing and recruitment

The practice had a stable staff team with the majority of staff employed for at least three years or longer. We looked at four staff recruitment records. The sample included clinical and non-clinical staff. Records contained evidence to demonstrate appropriate recruitment checks had been undertaken prior to employment for the most recent recruits. The records of the most recently recruited staff included relevant checks such as references, as well as criminal record checks by the Disclosure and Barring Service (DBS). The practice manager had systems in place to check clinicians maintained medical indemnity insurance. There was evidence to show qualifications claimed had been verified. We noted there was not always proof of identity on staff files. The practice recruitment policy suggested that pre-employment checks should be arranged but the policy did not specify what checks were required, for example DBS checks and proof of identity. They assured us this would be addressed in the event a new staff member was recruited to the team.

The practice manager told us that if a locum GP joined the practice on temporary basis they would make checks to ensure their registration with the GMC was valid and check NHS England's performers list. The practice manager demonstrated that nursing staff copied them into their Nursing and Midwifery Council (NMC) registration updates. The practice had systems in place to routinely check the professional registration status of the GP and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice.

Reception, dispensing and administration staff were multi skilled which enabled them to cover each other in the event of planned and unplanned absence. 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 were systems in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. 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

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence these checks were carried out weekly, monthly and annually where applicable. We found that the practice in general ensured the appropriate checks and risk assessments had been carried out. Fire extinguishers and alarms were checked and maintained by an external company.

Events and incidents were discussed at specific staff meetings. The practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

The practice had procedures in place to manage expected absences, such as annual leave, and unexpected absences, such as staff sickness. There was an accident book and staff knew where this was located. Staff reported that they always spoke to the practice manager or GP if an accident occurred. They knew where to record the information and confirmed this was shared with other staff to reduce the risk of it happening again. Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical

emergencies. For example staff we spoke with were clear in describing the actions they would take in the event of a patient with a long term condition requiring emergency intervention.

Arrangements to deal with emergencies and major incidents

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

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. When we spoke with staff we found they were aware of the business continuity plan and could readily access the hard copy. Each risk identified had mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Emergency equipment was readily available and included a defibrillator and oxygen. Checks were undertaken to ensure they were ready for use and in date. Staff were all aware of the location of the emergency drug box and emergency equipment and secure access arrangements were in place for clinical staff members.

Fire training was completed at induction according to the practice manager. We found that some staff had not had a fire drill that they could recall. Some staff could not recall when they had last completed fire training. Fire drills are essential in any workplace or public building for practicing what to do in the event of a fire and are a legal requirement under the Regulatory Reform (Fire Safety) Order 2005. Staff however knew what they would do in the event of a fire; the fire assembly point and the name of the designated fire marshall. The fire exits were well signposted and free from hazards to prevent escape in an emergency, there was a designated fire marshall and the fire systems had been serviced. The practice manager informed us the fire drill would be completed by 23 January 2015 and staff refresher training would be arranged. The practice could not locate a fire risk assessment on the day of the inspection which would include the actions required to maintain fire safety. The practice manager assured us that a fire risk assessment would be completed if it was not located. The practice informed us this would be acted on immediately.

The practice had a panic alarm system in place which if triggered would alert both the GP and the police to attend as it was directly linked to the police.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidelines from the National Institute for Health and Care Excellence and from local commissioners. We were told from regular review of treatments and prescribing, the practice was able to review medications and stabilise patients using current guidance and recommendations. We found from our discussions with the clinical staff that they completed thorough assessments of patients' needs and these were reviewed as appropriate. For example, the nurses actively screened patients for diabetes and monitored their long term conditions.

Arrangements were in place to identify patients who required annual reviews of on-going care and treatment to ensure it continued to be safe and effective. We saw that the practice was appropriately identifying and reporting incidents.

There were systems in place to ensure referrals to secondary care (hospitals) were made in line with national standards. Referrals were managed primarily by using the 'choose and book' system, or when urgent, a fast track system. Staff followed up on each referral to ensure that it had been received, was progressed in a timely manner, and the result received back at the practice. Requests for home visits were recorded by the reception staff, reported to the GP and patients visited. Patients spoke with and several CQC comment cards received commented they felt they were treated in an effective and timely manner.

On the day of the inspection the GP visited patients who resided at a care home following the patient's request for the need to speak with the GP. The GP explained that except in exceptional circumstances all patient requests for appointments or visits were met in general on the same day. We saw evidence that patients were referred promptly for specialist advice where required promptly and with the patients' involvement and understanding.

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care. New patient health checks were carried out by the practice nurses and regular health checks and screenings were on-going in line with national guidance.

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

Management, monitoring and improving outcomes for people

Staff at the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management. The information staff collected was then collated by the GP and could be used to support the practice to carry out clinical audits.

Care plans were in place for patients with complex or multiple health conditions including patients with mental health conditions and dementia. This enabled the practice to effectively monitor patients at regular intervals. The practice IT system generated alerts when patients were due for reviews and staff ensured they received them in a timely manner, for example, reviews of medicines and management of long term conditions. The practice had systems in place to follow up and recall patients should they fail to attend appointments, for example, non-attendance at a child vaccination appointment.

The practice maintained lists of patients with particular conditions and vulnerabilities. Care plans were in place for all patients identified as at risk of admission to hospital. The practice had a system in place for completing clinical audit cycles. A few examples of the clinical audits included dermatology referrals, diabetes, cancer diagnosis and a review of unplanned accident and emergency attendance prevalence. An example included improvement in controlling diabetic patients' blood glucose levels. Nine of the 14 patients deemed suitable for final analysis on average had improved.

Regular clinical meetings took place with the staff to share information and provide reflection and learning to the benefit of the patients. The GP had regular CCG peer group meetings and staff attended CCG meetings and shared their experiences and any learning.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks

Good

Are services effective?

(for example, treatment is effective)

were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GP had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included the GP, two nurses, the practice manager, reception/dispensary and administration staff and a cleaner. The practice had a training policy for both clinical and non-clinical staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. Some staff had last received periodic fire training in 2005 the practice manager assured us this would be addressed.

The GP was up to date with their yearly continuing professional development requirements. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). A locum GP covered the GP for leave or sickness.

All staff undertook annual appraisals that identified learning needs from which personal development plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example diabetes and cervical screening.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and infection control. Those with extended roles such as seeing patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice manager and staff confirmed that should poor performance be identified or gaps in knowledge and experience appropriate action would be taken to manage this.

Most of the staff were long serving but we saw new staff would have an induction which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care alongside mandatory training. All patients we spoke with were complimentary about the staff. We observed staff communicating with patients and they were professional, caring and knowledgeable about the role they undertook.

Working with colleagues and other services

The practice worked effectively with other health and social care services. We were provided with examples of effective communication such as the palliative care support staff. Blood test results, X ray results, discharge summaries and letters received from the local hospitals were managed in a timely manner. These communications were referred to the GP to ensure all incoming communications were seen and actioned by the GP before being added to the patients' electronic record. The GP was responsible for any amendments to any medications in patient records following hospital admissions. Information from the out of hour's service or when patients attended A&E were received the following day and addressed in the same way.

The practice had regular whole team meetings to discuss and manage the practice. Clinical staff meetings took place and clinical updates between nurses also took place via their electronic nurse messaging system. The GP was aware of the patients requiring palliative care and engaged with the local palliative care co-ordinator for the care of patients coming to the end of their life. Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hour's service in relation to patients receiving palliative care.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice. CQC comments cards also confirmed patients felt they had been referred for hospital appointments within an appropriate timescale.

Information sharing

Patient records were held electronically on a widely used primary clinical care system. This was used by all staff to coordinate, document and manage patients' care. The practice manager informed us that they used software which enabled scanned paper communications to be linked to an individual patient's records and saved in the system for future reference. The practice had a system for

Good

Are services effective?

(for example, treatment is effective)

transferring and acting on information about patients seen by other doctors out of hours. Electronic systems were also in place for making referrals to secondary care (hospitals). There was a fast track system for urgent referrals.

Information sharing took place with community health and social care teams on an individual patient basis with the GP attending palliative/supportive care meetings.

The out of hour's service and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). The practice website also confirmed to its patients that the SCR was automatically updated on at least a daily basis to ensure that their information was as up to date as it could be.

All staff completed training which included; information governance (IG) and confidentiality training. We saw the practice staff completed on line IG training which included; records management and the NHS Code of Practice, access to health records. The practice followed the guidelines of Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent. The practice had a named Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

Consent to care and treatment

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff told us they had received training in regards to consent but had not received formal training for the Mental Capacity Act 2005; however they assured us they could read the available documentation on line to ensure they were fully orientated with the requirements of the act. 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 practice. The GP maintained a record of any patients who had an agreed to a 'do not attempt resuscitation' order in place (DNACPR). Staff demonstrated their awareness of how patients should be supported to make their own decisions and how these should be documented. Staff informed us they had access to interpreter translation services for patients who needed it to maximise patients understanding to give informed consent. There was guidance about using interpreter services and contact details available for staff to use.

Staff had a good understanding of what was required to determine a patient's best interests and how these were taken into account, if a patient did not have capacity to make a decision. The practice had not needed to use restraint, but clinical staff were aware of the distinction between lawful and unlawful restraint. Clinical and non-clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity and understanding to consent to medical examination and treatment).

Health promotion and prevention

Patients were assisted to access support services to help them make lifestyle improvements and manage their care and treatment. All new patients were asked to complete a health questionnaire and offered a consultation. We found that clinical staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice.

We saw that staff in-depth knowledge of their patients' needs led to targeted services being in place such as childhood immunisation schedules being followed. At the time of inspection the practice was promoting flu vaccination. The practice staff supported patients with self-management plans for example with patients with asthma and diabetes.

We saw that there was a range of health promotion information on display in the waiting areas and leaflets explaining different conditions were also freely available in the treatment rooms of the practice. In the reception area we saw information for carers which provided signposting to support on a wide variety of issues. There was a practice website with information for patients including signposting, services available and latest news.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with two patients whilst in the practice and received 41 completed CQC comment cards. The comments on the cards we received were overwhelmingly positive in particular singling out the care and treatment provided by the GP. All comments were extremely positive in respect of the clinical and non-clinical staff at the practice, including staff approach, professionalism and support. Patients told us they felt listened to and were treated respectfully by staff. Patients said their privacy and dignity was maintained at all times. Patients told us staff were approachable, friendly and they valued and regarded the professionalism of the clinical staff and service provided highly.

All patient appointments were conducted in the privacy of a consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. 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 so that confidential information was kept private. We also saw that staff treated patients with kindness and respect.

We found there was a strong culture of patient centred care and ensuring a holistic approach to care was delivered by all staff. It was clear staff were motivated to provide the best possible care.

The patient electronic system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, a learning disability or if they had had a recent bereavement.

The latest NHS National GP patient survey published January 2015 reported that 97% of patients that would recommend their practice which was higher than the CCG and National average. Ninety-nine percent of patients who responded had confidence and trust in the last nurse they saw or spoke to, which was higher than the local CCG average. All respondents said the GP was good at listening to them and had confidence and trust in the GP. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 99% saying the GP gave them enough time.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that they felt involved in decisions about their care and treatment. Patients told us diagnosis and treatment options were clearly explained and they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do. Patients said the GP took time to understand and discuss their issues, and answer any questions they may have. All of the CQC comments cards we received were positive about all aspects of the service received at the practice. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture.

The 2015 national GP patient survey reported that 94% of respondents found their GP to be good at involving them in decisions about their care and 93% said the same of the nurses. Ninety-eight percent said the GP was good at explaining tests and treatments and 95% said the same of the last nurse they saw or spoke to.

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

Using a coding system on the computer system the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities. With the involvement of the patient, care plans had been put in place for anyone at increased risk of admission to hospital. All the staff we spoke with knew how to access an interpreter if required. Staff informed us that literature could be accessed in different languages as and when required. The practice manager demonstrated that they maintained a patient's carer register and the GP confirmed that all patients with a mental health condition or dementia registered at the practice had a completed care plan reviewed annually or when change occurred.

Patient/carer support to cope emotionally with care and treatment

The practice had systems in place that reflected best practice for patients nearing the end of their life and

Good

Are services caring?

demonstrated an ethos of caring and striving to achieve a dignified death for patients. We were told that in appropriate cases the GP had conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation with patients. This was to ensure patients' wishes were managed in a sensitive and appropriate way. Systems were in place to prioritise support according to estimated prognosis. Patient preferences were appropriately shared electronically with appropriate healthcare partners to ensure they were met, for example, with the out of hour's services.

The January 2015 national GP patient survey reported 96% of respondents found the GP they saw or spoke to was good at treating them with care and concern and 96% found the last nurse they saw or spoke to was good at treating them with care and concern. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.

The practice had information available for carers which provided signposting to support on a wide variety of issues. Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a variety of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice IT system for when recalls were due. The GP completed monthly reviews of patients on case management registers after an attendance at A&E, or following an unplanned admission, to reduce the risk of A&E attendance where appropriate to do so. For example between April and November 2014 there were 35 unplanned hospital admissions. The practice looked at factors that might have prevented admission. This analysis found that other than one admission none of the patient admissions could have been avoided. The practice forwarded their findings and any recommendations to the Clinical Commissioning Group (CCG). The practice informed us they engaged regularly with the local CCG and other practices in the GP peer group at the CCG to discuss local needs and initiatives to improve patient experience. This included improving access to the service for patients for appointments. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. On- line and telephone appointment booking were available and an extended one hour surgery took place every week.

The practice was considering the introduction of a patient participation group (PPG). A PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are taken into consideration and to work in partnership with the surgery to improve common understanding. Patients were encouraged to complete the Friends and Family test (FFT) which was operational at the practice. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience that can be used to improve services

The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients registered with the practice. This included educating staff, care planning and ensuring that their patients could access appointments more often than not on the same day. The GP ensured that requests for home visits to patients whose illness or disability meant they could not attend an appointment at the practice were timely. This was further supported in the NHS patient survey with all of the respondents saying the last appointment they got was convenient.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. We found the practice had policies in place aimed at tackling inequity and promoting equality, examples included policies regarding equal opportunities and identification of carers. The computer systems enabled staff to place an alert on the records of patients who had particular difficulties so staff could make reasonable adjustments. For example, if a patient had carer support, hearing impairment or learning difficulties.

There was level entry to the practice from the outside. The practice had a local arrangement in place for car parking as there was very limited car parking available. There was an adequately spacious waiting area. We noted there was no power assisted entrance door to the practice and the reception desk was not at a lower level to facilitate access by wheelchair users. Staff were aware of these limitations and informed us that they assisted patients through doors and to the treatment or consultation rooms when appropriate to do so. The GP and nurses individually invited the next patient for their consultation from the waiting room, so there were no issues around patients not hearing the call for their appointment or lack of mobility support to the treatment rooms. Accessible toilet facilities were available on the ground floor.

Public Health England's data found the practice's average male and female life expectancy was in line with the CCG and national average. Clinical staff provided health promotion information and advice on matters such as chronic disease management, immunisation and vaccination and diabetes.

Staff reported that there was little ethnic diversity within their patient population. However they were knowledgeable about language issues, they also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. Translation services were available if required. The practice had systems in place to ensure patients experiencing poor mental health (MH) had received an annual physical health

Good

Are services responsive to people's needs?

(for example, to feedback?)

check. We saw that the practice maintained a register of patients with a dementia diagnosis and the GP demonstrated that patients received regular reviews of their care and treatment.

Access to the service

The national GP patient survey 2015 found that 99% of patients described their experience of making an appointment as good, which was higher than the local CCG average. Ninety-five percent of patients found it easy to get through to the practice by phone which compared favourably to the local CCG average of 75%. This was based on 118 returned surveys from the 240 surveys sent out giving a 49% completion rate.

The practice was open Monday to Friday from 9am until 5.30pm with the exception of Thursday afternoons when the practice closed. The practice offered an extended service between 6.30 and 7.30pm every Monday. Emergency appointments were available every day as well as pre bookable appointments. When the practice was closed patients had access to the out of hours service, with contact telephone numbers provided in patient literature and on the practice answerphone. Patients could receive text reminders 24 to 48 hours prior to their appointment.

The nurse held morning surgeries between 9.00am and 11am Monday, Wednesday and Fridays and afternoon appointments 3pm to 5.30pm Tuesday, Wednesday and Fridays, in general by appointment. Home visits were available every weekday. All surgery opening times were detailed in the practice leaflet which was available in the waiting room for patients and website.

Responses to the national and practice patient survey showed that patients were satisfied with the practice. This was consistent with the responses we received on CQC comment cards. In the national survey all respondents said the last appointment they got was convenient and 99% were able to get an appointment to see or speak to someone the last time they tried. Patients reported they were seen in a timely manner and our observations on the day in general confirmed this.

From the completed CQC comment cards and speaking with patients we were told that the practice offered a responsive appointment service as patients reported it was not difficult to get through by telephone to make an appointment. This was also reflected in the NHS England January 2015 patient survey when it was reported that 95% of respondents found it easy to get through to the practice by phone. Previous GP surveys had also reported high levels of patient satisfaction in the appointment system. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or at the request of the GP.

When the practice was closed the care and treatment needs of patients were met by an out of hour's provider. Contact information for this service was well publicised.

Listening and learning from concerns and complaints

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

We reviewed how the practice managed complaints within the last 12 months. We saw that very few clinical and non-clinical complaints had been made by patients or their family and all had been resolved. We found the practice handled and responded to complaints well. The practice complaints policy stated the time frames in which complaints should be acknowledged, investigated and resolved within. We saw that complainants had received acknowledgement of the complaint and complaints were investigated and documented in a timely manner as required. Investigations addressed the original issues raised and action was taken to rectify problems. These were discussed at practice meetings and where changes could be made to improve the service these were put in place. Complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks. Actions from complaints were shared with staff as appropriate. This was verified with staff and through staff meeting minutes.

All the staff we spoke with were aware of the system in place to deal with complaints. They told us feedback was welcomed by the practice and seen as a way to improve the service. We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken

Good

Are services responsive to people's needs?

(for example, to feedback?)

with had needed to make a complaint about the practice. We saw the practice invited patients to complete feedback in the form of the Friends and Family test, a recent national initiative.

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

Discussions with staff and evidence we reviewed identified that the management team had a clear vision and purpose. The GP and nurses we spoke with demonstrated a clear understanding of their responsibilities and they took an active role in ensuring that a high level of service was provided on a daily basis. There was a clear team working ethos that demonstrated all staff worked to a common goal and had contributed. Most staff had been working at the practice for a number of years and had been part of the development of the service.

All staff were clear of their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon.

The practice leaflet and website stated the practice was interested in the views of their patients and carers and these views were fed into the practice at meetings so they could consider how the service could be improved.

Governance arrangements

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

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. The practice manager and GP took an active role in overseeing the systems in place to ensure they were consistent and effective. They ensured policies and procedures were kept up to date and that staff received training appropriate to their role. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice and within a hard copy folder which staff could readily access. We looked at eight of these policies and procedures and staff had completed a cover sheet to confirm that they had read the policy and when. All had been reviewed regularly and included the next due date for review. During the inspection the practice manager was made aware of any areas to be addressed such as fire drills, risk assessment and refresher training and Legionella checks. We were assured that the practice would review guidance and information sources and undertake appropriate actions accordingly.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP was the lead for safeguarding with a nurse as their deputy lead. We spoke with five staff members and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice nurses told us they attended practice nurse meetings where able which enabled peer review support and the GP peer support was with their CCG peer group. We looked at the practices latest team and clinical support meetings, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement. We saw for example that staff had discussed the introduction of the Family and Friends Test to gather patients' views. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example they had completed a review of unplanned hospital admissions between April 2014 and November 2014.

There was evidence that feedback from patients was discussed with all staff and any resultant actions or learning was applied.

Leadership, openness and transparency

We spoke with staff and all were very clear about the vision and values of the practice. There was an open and honest culture and clinical, administrative and reception staff all encompassed the concepts of compassion, dignity, respect and equality. We observed a friendly relationship between reception staff and patients. Patients spoke very fondly of the reception team. Staff understood their roles, were clear about their responsibilities and contacted clinical staff when appropriate to do so.

Staff felt supported in their role and were able to speak with the practice manager or GP at any given time. Staff told us they felt valued for the work they provided. The

Are services well-led?

Good

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

practice manager undertook appraisals for the reception and administration team and the GP with nursing staff appraisals on an annual basis. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. The practice manager had her appraisal carried out by the GP.

The culture at the practice was open and fair. We saw from minutes that staff practice meetings were held regularly. Staff told us they felt comfortable raising any issues or concerns and had the opportunity to discuss and air their views at these meetings.

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

The practice conducted an annual survey of patient feedback which included the opportunity for patients to comment on any aspect of the service they felt could be improved or was particularly good. We saw evidence that feedback was analysed and discussed with staff to see if there were any common themes where improvements could be made

Staff we spoke with told us they were asked for their opinion on matters concerning the practice and they told us they felt comfortable making any suggestions to improve the service. Staff said the management team constantly looked for areas where they could improve and there was an ethos of improving outcomes for patients and staff within the practice.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns and knew the contact details of senior staff within the practice who they could contact if required.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction. Learning objectives for existing staff were discussed during appraisal and mandatory training was role relevant. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. E-learning was carried out. The GP was supported to obtain the evidence and information required for their professional revalidation. Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge. Nurses we spoke with told us they would discuss particular cases and reflect on them to enhance their care and management of patients but also to share good practice.

The practice was actively involved in the CCG long term strategy plan and also local and national initiatives to improve patient care. The GP was involved in local clinical meetings. Similarly the practice nurses and practice manager attended their professional forum groups to provide training and support and share good practice.

The GP discussed the challenges for all services however the practice aimed to be innovative and participated in future local developments, working closely with other practices and the CCG. The practice completed reviews of significant events and other incidents and shared results and findings with staff at specific staff meetings to ensure the practice learned from and took action, which improved outcomes for patients.