Dr NK Shah

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

Our key findings were as follows:

- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was responsive to the needs of patients and operated a flexible system for routine health reviews and promotion appointments.
- The practice performed above or in line with local and nationally set targets for assessing and meeting the needs of patients.
- The practice was well managed with staff and patients reporting that they felt valued and were involved in making decisions.

However, there was an area of practice where the provider needed to make improvements.

The provider should:

- Ensure that records are maintained that evidence risk assessments, investigation of complaints and other events, which are carried out.
- Ensure that there are clear cleaning schedules that describe the cleaning for clinical areas.
- Review the arrangements for making test results available to patients where they fail to contact the surgery.

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 good for safe. Staff understood their responsibilities to raise concerns, and report incidents and near misses. .

The practice had systems in place for assessing risks of health acquired infections and there were policies and procedures available to staff. There were no health and safety risk assessments in place to identify and manage risks to patients and staff.

The practice had fire safety procedures in place and fire drills and evacuation exercises were carried out.

There were policies and procedures in place for providing chaperones during physical examinations.

Are services effective?

Good

The practice is rated as good for effective. Data we had access to showed that the practice was achieving results that were in line with or better than the national or local Clinical Commissioning Group average in all areas of assessment and delivery of patient care. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) and local guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation.

The practice was proactive in the care and treatment provided for patients with long term conditions such as asthma and diabetes and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for most aspects of care. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them.

Summary of findings

We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that emergency appointments were available the same day.

Patients had access to information to help them raise concerns or make complaints if they were unhappy. Complaints were dealt with by the senior GP partner. However complaints were not consistently logged with details of investigations carried out and learning to help avoid recurrence.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice.

The practice proactively sought feedback from staff and patients and this was acted upon. The practice had an established patient participation group (PPG). A patient participation group is a forum made up of patients and staff who meet to share information and help influence changes and improvements in general practices. There was evidence that the practice had a culture of learning, development and improvement.

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

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and were included on the practice's 'unplanned admissions avoidance' list to alert staff to people who may be more vulnerable. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its flu vaccination programme. The practice nurse had arranged to attend patient's homes if their health prevented them from attending the clinics at the surgery. The practice worked with a local care home to provide a responsive service to the people who lived there.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice

for annual and half yearly reviews of their health. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. 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.

People whose health prevented them from being able to request GP visits to them at home (including patients in the local care home the practice supports). Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked in person or by telephone. Appointments could be booked up to two weeks in advance.

Information and advice was available to promote health to women before, during and after pregnancy. Expectant mothers had access

to midwife clinics every week. The practice monitored the physical and developmental progress of babies and young children. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

Records showed that cared for children (such as those in foster care), those subject to child protection orders and children living in disadvantaged circumstances were discussed and any issues shared and followed up at monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Appointments for childhood immunisations were available at times to suit patients.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group 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. Appointments could be booked in person or by telephone. Appointments could be booked up to two weeks in advance.

Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on their website. Nurse led clinics were provided each week for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio, and hepatitis A was available within the practice waiting area.

When patients required referral to specialist services they were offered a choice of services, locations and dates.

Summary of findings

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of patients who had learning disabilities. All patients with learning disabilities were invited to attend for an annual health check.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients were referred to local counselling sessions where appropriate and patients were provided with information how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 36 CQC comment cards patients had completed. The responses from the comment cared were overwhelmingly positive with all those who completed them commenting on the ease of making appointments and the kindness of staff at the practice.

We also spoke with five patients, one of whom was involved with the practice Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to work in partnership with the practice to promote and improve how the service is provided. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the NHS England GP patient survey showed that the practice scored in the upper range nationally for satisfaction with the practice. The practice scored highly for patient satisfaction with the availability of appointments, their involvement in making decisions about their care and treatment and how they were treated by staff.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that records are maintained that evidence risk assessments, investigation of complaints and other events, which are carried out.
- Ensure that there are clear cleaning schedules that describe the cleaning for clinical areas.
- Review the arrangements for making test results available to patients where they fail to contact the surgery.

Dr NK Shah

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 and a practice nurse specialist advisor.

Background to Dr NK Shah

Dr NK Shah is located on the outskirts of Southend on Sea town centre. The practice provides services for approximately 2,200 patients living in the area from their surgery on North Avenue. The practice has no branch surgeries.

The practice is managed by two partners, Dr Manish Shah and Dr Natverlal Shah. The practice employs one long term locum GP, one practice nurse, who works part time, a practice manager and three reception staff.

Dr NK Shah is not a teaching practice. The practice does not provide dispensing services.

Appointments were available between 9am and 11.30am and between 4pm and 6.30pm. Routine appointments could be pre-booked up to two weeks in advance. Home visits and telephone consultations were available as required.

Dr NK Shah does not provide an out-of-hours service to patients. Details of how to access out-of-hours emergency and non-emergency treatment and advice was available within the practice.

Why we carried out this inspection

We inspected Dr NK Shah as part of our new comprehensive inspection programme.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- 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 and asked other organisations to share what they knew. We carried out an announced visit on 18 November 2014. During our visit we spoke with the senior GP partner, practice manager, the locum GP, practice nurse, three receptionists and the cleaner. We spoke with patients

Detailed findings

who used the service. We talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety.

The practice manager told us that complaints, concerns and significant events were discussed at monthly meetings and records we viewed confirmed this. However staff we spoke with could not give any examples of learning or changes to practices as a result of complaints received or incidents, which had occurred. Staff told us that Dr Shah dealt with and resolved all complaints as they were raised.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. However we did not see evidence that accidents, significant events and any other safety incidents were fully investigated. A root cause analysis had not been carried out to determine where improvements could be made and to identify learning opportunities to prevent recurrences.

Records were kept of significant events that had occurred during the last twelve months and these were made available to us. Two events had been recorded, one in relation to a problem with the practice computerised system and one about the theft of a patient's mobile telephone. There were no records in respect of any clinical significant incidents or 'near misses' or evidence of learning or changes in practices arising from instances where things went wrong.

Staff including receptionists, administrators and nursing staff told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding adults and children. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated lead for safeguarding vulnerable adults and children who had oversight for safeguarding and acted as a resource for the practice. Staff we spoke with were aware of who the lead was and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example looked after for children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed at weekly GP meetings and monthly multidisciplinary team meetings which were attended by health visitors, district nurses and school nurses. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed followed up, and appropriate referrals were made as required.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. A review of staff records showed that chaperone training had been undertaken by members of staff. Patients we spoke with were aware that they could request a chaperone during their consultation, if they chose to.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on the practice electronic system which collated all

communications about the patient including scanned copies of communications from hospitals. We saw evidence that staff had undertaken training in the use of the electronic system and audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

Medicines were generally managed safely so that risks to patients were minimised. There were suitable arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for antibiotics, hypnotics and non-steroidal anti-inflammatory medicines were similar to the national average. Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets and posters. Patients could order repeat prescriptions in person, by fax, post or by email. We found that the GP regularly used 'post it' notes to communicate changes and actions for staff to complete in relation to repeat prescriptions, increasing the risk for errors as the notes could be mislaid. Through discussion with staff including the GPs we found that while there were arrangements for ensuring that patients' blood levels were routinely monitored to ensure that medicines were prescribed safely and effectively, the practice relied on patients telephoning or making appointments and did not proactively contact patients with test results.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice employed a cleaner each day for general cleaning. We saw there were cleaning schedules in place for general areas. The practice nurse told us that they were responsible for cleaning the treatment room. They confirmed that there were no schedules for cleaning of clinical areas. The practice manager and practice nurse told us that they carried out visual checks each day, but confirmed that there were no records kept in respect of these checks.

The practice had in place infection control policies and procedures for staff to follow, which enabled them to plan and implement control of infection measures. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. All staff had undertaken infection control training and clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. Staff were provided with appropriate personal protective equipment.

Dr Shah acted as the clinical lead for infection control, supported by the practice manager as non-clinical lead. Both had undertaken further training to enable them to provide advice on the practice infection control policy. An infection control audit had been carried out in March 2013 by the practice manager.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales, thermometers

and emergency equipment such as an automatic external defibrillator (used to attempt to restart a person's heart in a cardiac emergency) were periodically checked and calibrated to ensure accurate results for patients.

We saw records showing that other equipment required for the safe running of the practice, including fire detecting and fire fighting equipment was checked and replaced as required. Portable electrical equipment was PAT tested annually. PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use.

Staffing & Recruitment

The practice had robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. The practice recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. Employment references and criminal records checks were in place for all staff working at the practice. There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us there were always enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures or adverse weather conditions. Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness.

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, which staff were aware of. We saw that a health and safety risk assessment had not been carried out to help identify risks to staff and patients.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Emergency equipment and medicines were available at a dedicated place within the practice, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in a cardiac emergency). All staff asked knew the location of this equipment and records we saw confirmed these were 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 (allergic reactions) and hypoglycaemia (low blood sugar). Processes were also in place to check 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. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. The GP confirmed that annual fire drill and evacuation exercises were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information, new guidance were made available in information folders and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments. We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance assessing and treating patients with long term conditions such as diabetes were generally in line with or higher that the local Clinical Commissioning Group (CCG) averages.

The practice GPs took a lead role in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. The practice nurse carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This helped the GPs to treat patients with more complex medical conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate on going quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. The GPs told us clinical audits were often linked to medicines management information, safety alerts. We looked at the records for one completed clinical audit, which had been carried out around the use of combined drug therapy in the treatment of type 2 (non-insulin dependent) diabetes. The audit monitored patients weight and plasma glucose levels to ensure that the combination of medicines was effective in reducing the patients weight and achieving the desired blood sugar levels so as to ensure that medical conditions and prescribing practices were in line with current National Institute for Health and Care Excellence (NICE) guidelines, in the best interests of patients and cost effective.

We looked at the data and information we had about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was higher than the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as diabetes, dementia, learning disabilities and mental health disorders. The practice kept a register of patients who were receiving palliative care and treatment and were monitoring and planning care in line with the requirements of these services.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff described the process for ensuring that repeat prescriptions were checked and reviewed and the processes for alerting the GPs if they had any concerns about repeat prescriptions. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs reviewed the use of the medicine in question, prescribed alternatives or, where they continued to prescribe it 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 and reviewed their treatments appropriately.

Effective staffing

The practice employed staff who were appropriately skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for three members of staff.

Good

Are services effective?

(for example, treatment is effective)

We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Staff we spoke with told us that the GP provided opportunities for learning and that they undertook a range of online and face-to-face training. Records we viewed confirmed this.

All new staff underwent a period of induction to the practice. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices. We spoke with one member of staff who told us that they had a tailored period of induction with support from more senior colleagues.

Individual staff performance was assessed and training and development needs were identified through an annual appraisal system. Staff had personal development plans that detailed their planned learning and development objectives, which were kept under review. We saw that where staff had identified training interests that arrangements had been made to provide suitable courses and opportunities. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had dedicated leads for overseeing areas such as safeguarding, infection control, palliative care and learning disabilities. The practice nurse had undertaken specific training in health promotion and the treatment of minor illness such as, acute asthma, smoking cessation and sexual health screening. The nurse provided services including well person checks, long term condition reviews, family planning and cervical screening. This enabled the doctors to focus on more complex problems and conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the NHS 111 summaries were reviewed and actioned on the day they were received.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were attended by district nurses, health visitors, social workers and palliative care nurses where decisions about care planning were documented in a shared care record. We looked at the records for the last six meetings and found that detailed information was recorded, reviewed and shared to ensure that patients received coordinated care, treatment and support.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had undertaken training on the system. Staff told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care. We saw that treatment records for patients who had used the 'out-of-hours' service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment.

GPs and nurses at the practice worked closely with Macmillan nurses and other agencies who support people with life limiting illnesses. They held a monthly palliative care meeting to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs.

Staff were alert to the importance of patient confidentiality and the need to obtain appropriate consent. They gave us an example of a situation where a receptionist had checked a request with a GP before sharing any information with a third party.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

The practice had policies and procedures in place for obtaining patient's consent to care and treatment. The procedures included information about people's right to withdraw consent. GP's and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children and they told us that they obtained parental consent before administering child immunisations and vaccines.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, reception and entrance hall where patients could see them. These included information to promote good physical and mental health and lifestyle choices. We saw information about mental health, domestic violence advice and support that was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation and alcohol consumption. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. We saw that of the100 patients who had registered with the practice since April 2014 that 50% had received a new patient check and the practice was on target to achieve 100% of these health checks. Nurse led clinics and pre-booked appointments were available including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma clinics.

Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Data we looked at before the inspection showed that the practice was performing in line with other practices in the area for take up of childhood immunisations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 36 CQC comment cards that patients had filled in and spoke in person with six patients. The response from patients was overwhelmingly positive with all patients reporting that all staff at the practice were kind, caring and helpful. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients said they felt the practice provided excellent care and treatment.

We reviewed the most recent information available from the national patient survey, which was carried out in 2013. This showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example 92% of patients who completed the national patient survey said that the GP was good at listening to them and 86% said that the GP was good at giving them enough time.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. Reception staff told us that where patients wished to speak privately to a receptionist, they were offered the opportunity to be seen in another room. During the inspection we spent time in the reception area. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so.

The practice had a range of anti-discrimination policies and procedures and staff told us 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 practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The patient national GP survey information we reviewed showed that patient's responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 87% of patients said that the GP was good at involving them in decisions about their care, and 95% said that the GP was good at explaining tests and treatments.

Patients we spoke to on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that information in relation to their health and the treatment that they received was explained to them in a way that they could understand. Patient feedback on the comment cards we received was also positive and each of the 36 patients who responded told us that they were happy with their involvement in their care and treatment.

Staff told us that the majority of patients were English speaking. They told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

Good

Are services caring?

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

Staff told us families who had suffered bereavement were called by the GP. This call was either followed by a patient consultation at the practice or a home visit where this was more appropriate. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice manager told us that the majority of patients were English speaking and that they had very few patients from black and ethnic minority communities. They practice provided care and treatment for a small number of people who were homeless and people who had alcohol or substance misuse problems. They told us that they worked well with local drug and alcohol teams to provide appropriate support to patients .

Patients who needed extra support because of their complex needs were allocated a longer time for their appointments. We saw specific tailored care plans to meet their needs for patients with learning disabilities and for those affected by dementia as well as those with long term medical conditions.

Access to the service

Staff at the practice understood the needs of the practice populations and had developed an appointment system to meet the needs of patients from the different population groups. Details of the services available, how to book, change or cancel appointments were posted throughout the practice. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. The practice did not have an active website, however patients could book routine appointments through the practice computerised system (SystmOne)

Patients we spoke with and those who completed a CQC comment card did not have any concerns about accessing appointments. A number of patients commented about the ease of making same day appointments for urgent assessments and treatment. From the national GP survey data we saw that the majority of patients expressed satisfaction with the appointment system at the practice. Appointments were available between 9am and 11.30am, and between 4pm and 6.30pm. Routine appointments could be pre-booked up to two weeks in advance. The practice previously provided extended hours; however these had been discontinued because they were not well used.

The practice is located in a single building with wheelchair accessible access. 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.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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.

There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. This information included details of the timelines for investigating and responding to them. This information was available within the practice waiting area. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Staff were aware of these procedures and the designated person who handled complaints. Doctors, nurses and administrative told us that the practice had an open culture where they felt safe and able to raise concerns. They told us

Good

Are services responsive to people's needs?

(for example, to feedback?)

learning from complaints and when things went wrong was shared through meetings and that there were mechanisms in place for making improvements as needed to help minimise

We were told by the GP that there had been no complaints received within the previous 12 months. Upon further discussion with the GP and other staff we found that where patients made complaints, Dr Shah would deal with the issue directly. While this helped to resolve individual patient complaints and concerns, there were no systems in place for monitoring trends in complaints and reviewing these to improve or change practices where needed.

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 and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were aware of the vision and values for the practice. The practice team shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews, audits and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. The majority of staff had lead roles, these included infection control, palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working and in practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. We saw examples of completed clinical audit cycles demonstrating that the practice was reviewing and evaluating the care and treatment patients received.

Leadership, openness and transparency

All staff we spoke with told us that Dr Shah was approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held weekly meetings and met more frequently where required to discuss any issues or changes within the practice.

Practice seeks and acts on feedback from users, public and staff

The practice had a Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Members of the patient group said that they were able to help inform and shape the management of the practice in relation to patient priorities, any planned practice changes and the outcomes from local and national GP survey.

The practice also tried to capture the views of patients by inviting them to leave comments or suggestions in a comments box, which was situated in the entrance lobby. The practice manager told us that the comments box was checked regularly but that it was not well used by patients.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality patient care.

Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

Staff told us that the practice supported them to maintain their clinical professional development through training

Are services well-led?

Good

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

and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected time for learning and personal development.