Dr Ranweer Baldevdutt Silhi

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 Ranweer Baldevdutt Silhi (also known as Upper Canterbury Street Surgery) on 25 November 2014. During the inspection we spoke with patients, interviewed staff of all levels and checked the right systems and processes were in place. Overall the practice was is rated as good.

This is because we found the practice to be good for providing effective, caring, responsive and well led services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing safe and well-led services.

Our Key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, but no analysis had been carried out. However, the practice could not demonstrate that any learning had occurred from significant events and incidents.
- Risks to patients were assessed and well managed
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought

Summary of findings

feedback from staff and patients, which it acted on. Some audits had been carried out. However, there was little evidence that audits were driving improvement in performance to improve patient outcomes

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 report incidents and near misses. The practice could demonstrate that lessons were learned and outcomes communicated to support improvement. Information about safety was recorded. Risks to patients were assessed and managed. The practice had adequate staffing to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information

Summary of findings

about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity. There were systems to monitor and improve quality as well as identify risk. However, these were not always completed. Although some audits had been carried out, there was little evidence that audits were driving improvement in performance to improve patient outcomes as they had not been completed, re-visited or the information shared with practice staff. The practice sought feedback from staff and patients, and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions and regular performance reviews.

Summary of findings

What people who use the service say

During our inspection we spoke with five patients and received 30 completed comment cards.

All the patients we spoke with were pleased with the quality of the care they had received. The themes running through the comments cards and the patient interviews were that the staff were very kind and considerate. Several patients commented on how referrals were made quickly and with patients' involvement

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 299 survey forms were sent out and 108 were returned. The main results from that survey were:

- Patients found it easy to get through to the surgery by telephone
- Patients reported that the experience of making an appointment was good
- Patients said that their overall experience of the practice was good
- 80% of patients indicated that they would recommend the practice to others which was higher than the national average.

Dr Ranweer Baldevdutt Silhi

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Ranweer Baldevdutt Silhi

Dr Ranweer Baldevdutt Silhi (also known as Upper Canterbury Street Surgery) provides primary medical services for approximately 1,500 patients in Gillingham, Kent and the surrounding areas. The practice has a higher than the national average percentage of patients over 65 years. The number of people in the area who are unemployed is higher than the national average.

There is one male GP. The practice provides 11 GP sessions each week, one session being half a day. There are two female practice nurses who provide two sessions each week and a female health care assistant who provides one session on a Monday afternoon. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is not a training practice.

Services are delivered from:

Upper Canterbury Street Surgery,

511 Canterbury Street,

Gillingham, Kent,

ME7 5LH.

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

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

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

Detailed findings

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 25 November 2014. During our visit we spoke with a range of staff including a GP, 2 nursing staff, 2 receptionists and administrators and the practice manager We spoke with five patients who used the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example, they considered reported incidents and accidents, national patient safety alerts as well as comments and complaints received. This was a small practice and staff we spoke with felt confident they could raise any safety issues with the GP and nursing staff. Staff were aware of their responsibilities to raise concerns and knew how to report incidents or near misses. The practice could demonstrate that lessons were learned and communicated to staff to support improvement. Information about safety was recorded.

We reviewed safety records, eight incident reports and minutes of meetings for the last year which did not show that the incidents had been discussed. However staff could demonstrate the learning gained from them. The practice provided meeting minutes with significant event discussions and outcomes following our inspection. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year. The practice could demonstrate that learning had taken place from these events and action had been carried out to reduce the risks to patients and/or staff.

Staff used incident forms and sent completed forms to the practice manager. We looked at the system used to manage and monitor incidents. We tracked eight incidents. Records were completed but were brief. There was evidence of action taken as a result. For example, a refrigerator that contained vaccines had been unplugged overnight. Staff contacted Kent and Medway Screening and Immunisation Programme staff for advice and disposed of the vaccinations in the clinical waste. New vaccinations were ordered and a system of checking introduced to make sure that the refrigerator remained plugged in. A bold sticker was placed over the plug to remind staff not to remove it.

National patient safety alerts were disseminated by informal discussion to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed as and when they arose during daily informal meetings to help ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns as well as how to contact the relevant agencies in and out of working hours. There were policies for safeguarding vulnerable adults and vulnerable children containing guidance for staff that included the names and contact details of organisations to whom staff could report any allegations of abuse?

The practice had appointed the GP as the lead in safeguarding vulnerable adults and children. Records confirmed they had the necessary training (to Level 3) to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to enable them to act as a chaperone.

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure

that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed that practice staff had followed the policy when the refrigerator had been unplugged overnight.

The practice had a process to check that medicines were within their expiry date and suitable for use for the vaccinations. However, there was no system to check the emergency medicines. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

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

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

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

Cleanliness and infection control

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

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

An infection control policy and supporting procedures were available for staff to refer to, which helped enable them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

Equipment

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

Staffing and recruitment

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

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

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

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of

Good

Are services safe?

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Emergency equipment was available including access to medical oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). . Records showed that staff had received training in basic life support. However, this training had expired for two members of staff and none of the staff had received training in the use of the AED. Staff told us that they had booked training which included the use of the AED and we saw an email confirming this. When we asked members of staff, they all knew the location of this equipment. However, there were no records to confirm that it was checked regularly. The practice provided us with documentation that had been implemented to check the medicines regularly following our inspection.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not have a process to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

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

Are services effective?

(for example, treatment is effective)

Our findings

Our findings

Effective needs assessment

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

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

The GP showed us data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice used a system to review patients recently discharged from hospital, which required patients to be reviewed within one week by their GP according to need.

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

Discrimination was avoided when making care and treatment decisions. The culture in the practice was that patients were cared for and treated based on individual need and the practice took into account of patient's age, gender, race and culture as appropriate. Irrespective of patient's age, gender or beliefs

Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last year. One of these was complete. The practice was able to demonstrate the changes resulting since the initial audit. Other audits such as an antibiotic prescribing audit did not demonstrate a clear standard of measurement, findings, or how this would improve clinical service. Staff told us the practice needed carry out further work in this area.

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

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice scored highly for its ability to diagnose the common long-term conditions that were assessed by QOF such as diabetes and asthma. In this regard the practice had improved its own performance over the last few years and was consistently above the local and national averages. We looked at nine clinical areas. In all of them the incidence of diagnosis of the condition had improved.

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

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

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The GP was available at any time for patients on the palliative care register. Families were given the GPs personal telephone number so that they could ask advice or request help at any time of the day or night.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that most staff were up to date with attending mandatory courses such as annual basic life support. The GP was up to date with their yearly continuing professional development requirements and had been revalidated. (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).

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

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 and cervical cytology. Those with extended roles such as seeing patients with asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had a system for transferring and acting on information about patients seen by other doctors out of hours and patients who had been discharged from hospital.

The practice had a system to refer patients to other services such as hospital services or specialists. The practice monitored referrals to help ensure patients received appropriate appointments with other health professionals in a timely manner.

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

Information sharing

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Are services effective?

(for example, treatment is effective)

record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in patients' records for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a policy to help staff. For example, with making do not attempt resuscitation orders. This policy highlighted how patients were supported to make their own decisions and how these were documented in the medical notes.

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

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The GP used their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. The GP was a trained hypnotherapist and offered patients registered at the practice, as well as patients referred form the local hospital and other GP practices in the locality, help with smoking cessation, phobias and anxiety issues.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 67% of patients in this age group took up the offer of the health check. Patients were followed up within two weeks if they had risk factors for disease identified at the health check and further investigations scheduled if necessary.

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

The practice's performance for cervical smear uptake was 87.9% which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. There was also a member of staff responsible for following up patients who did not this attend screening.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 2 comments were less positive but there were no common themes to these. We also spoke with 5 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients commented on how they liked to always see the same GP. That they did not have to explain past problems and that the GP knew them well.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were not provided in the two consulting rooms to help maintain patients' privacy and dignity during examinations, investigations and treatments. Staff told us that curtains had been ordered and they were awaiting delivery. We saw an order request to support this. We received confirmation following our inspection that the curtains had arrived and had been put up in both rooms. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice telephones were located away from the reception desk and were shielded by a glass partition which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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

Care planning and involvement in decisions about care and treatment

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

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

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

Patient/carer support to cope emotionally with care and treatment

Are services caring?

Comment cards we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, patients shared with us their recent experience of bereavement and how the practice supported the whole family through a difficult time. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with how staff responded compassionately when they needed help and provided support when required.

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

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Such as more appointments with the nurses.

Tackling inequity and promoting equality

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

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

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

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was accessible by steps leading into the building. The practice had a ramp which was used to help patients in wheelchairs or mothers with pushchairs access the building. Staff told us that patients in wheelchairs were identified on the computer so that a member of staff would be available to help them access the building at the time of their appointment. Patients had the option of a home visit if they preferred where mobility was a problem.

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

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

Access to the service

Appointments were available from 8am to 12noon and 2pm to 6pm on Mondays and Tuesdays. Thursday was a half day from 8am to 12pm. Patients were able to attend another practice in close proximity on Thursday afternoons. This was a reciprocal arrangement. Between 12pm and 2pm patients were directed to the out of hours service. Staff told us that home visits were made as well as visits to local care homes between the hours of 12 noon and 2pm daily. The practice was open until 6pm Monday, Tuesday, Wednesday and Friday when patients could attend after working hours or attend the early clinics starting at 7.30am on a Wednesday and Friday.

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

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

Patients were generally satisfied with the appointments system. They said they could see a doctor on the same day if required and told us they liked the fact they always saw the same doctor. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints system such as posters in the waiting areas.

Are services responsive to people's needs?

(for example, to feedback?)

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

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

Are services well-led?

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

Our findings

Vision and strategy

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

The GP was preparing to take a phased retirement in approximately three to five years. There has been discussions and planning with NHS England and the local area team of the CCG to decide how best to carry out long term planning for the practice and patient population.

Governance arrangements

The practice had policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures. All 10 policies and procedures had been reviewed annually and were up to date. However, some of the information contained in the policies was not relevant to the practice or was out of date despite the policy having a current reviewed date. We brought this to the attention of the practice manager who has provided copies of the corrected policies following our inspection.

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

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

The practice participated in a local peer review system with neighbouring GP practices. Meetings held were bi monthly and the forum was used to discuss cases and current trends.

The practice didhave a programme of clinical audit cycles to monitor quality and systems. There had been some clinical audits carried out. However, all but one had not been completed.

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

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and make comments about the practice. Receptionists we spoke with said that they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. All the staff had responsibility for different activities. For example, for checking on QOF performance.

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

The practice had gathered feedback from patients through patient surveys and their patient participation group. We looked at the results of the last patient survey carried out in November 2013. 50 survey forms had been sent out and 46 completed surveys received. The overall consensus was that the patients who participated were happy with the services they had received. The survey had identified that it was often difficult to get an appointment with the nurse. As a result a health care assistant had been employed and provided a further afternoon session so that the practice nurse had more availability.

The practice had a patient participation group (PPG) which had six members. The PPG included representatives from the older person's patient population group. The practice had found it difficult to recruit other patients in other patient population groups despite a drive to do so. The PPG carried out annual surveys and met three monthly. There was analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice's website.

Staff we spoke with felt that the practice was open to suggestions from staff. They said that they were made

Are services well-led?

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

aware of comments and complaints through the daily meetings held and through emails. It was through patient suggestions that the practice had instigated additional opening hours on Friday mornings.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

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

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