

Dr Kiren Kaur

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Kiren Kaur on 25th March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, responsive and safe services. It was also good for providing services for the populations groups we rate.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- 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, however there was no evidence of the system being put into practice.
- Patients said they found it easy to make an appointment 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.

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

Importantly the provider should

- Ensure full clinical audits take place.
- Ensure patients with a learning disability receive the required health checks and annual reviews in a timely manner.
- Ensure complaints are handled and monitored in line with the practice policy.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated via team meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training and updates had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for caring. Patients said 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. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Area Teams and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice 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 an accessible complaints system; however there was no evidence of the system being put into practice.

Good



Are services well-led?

The practice is rated as good for well-led. The practice had clear aims to deliver good outcomes for patients. Staff were clear about the aims and their responsibilities in relation to the practice. There

Good



Summary of findings

was a clear leadership and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings.

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

The practice is rated as good for the population group of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people including patients with Chronic obstructive pulmonary disease (COPD); however the practice fell below local and national average outcomes for patients with diabetes and Hypertension.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia, shingles vaccinations and end of life care. The care for patients at the end of life was in line with the Gold Standard Framework. This means they work, as part of a multidisciplinary team and with out of hours providers to ensure consistency of care and a shared understanding of the patient's wishes.

The practice was responsive to the needs of older people, the GPs and nurses provided home visits and appointments for those in residential or nursing homes, with rapid access appointments for those with enhanced needs.

We saw care plans were in place for patients at risk and those aged 75 and over who were vulnerable.

The practice had achieved 76% vaccination rate for the influenza vaccine for those over 65, just above the local average.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. The practice has an electronic register of patients with long term conditions and has a recall system in place to ensure patients are called for a review annually so the condition can be monitored and reviewed.

The national Quality Outcome Framework (QOF) 2013/14 showed 100% of the outcomes had been achieved for patients with asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average, however the practice fell below local and national average outcomes for patients with diabetes and Hypertension.

Good



Summary of findings

For those people with the most complex needs GPs worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up vulnerable families and who were at risk.

Immunisation rates were high for all standard childhood immunisations. The practice had above average vaccination rate for the influenza vaccine for children aged two, three and four years old.

Appointments were available outside of school hours and Children with long term conditions appointments and reviews were accommodated with during school holidays.

All of the staff were responsive to parents' concerns and ensured parents could have same day appointments for children who were unwell.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice offered online services as well as a full range of health promotion and screening which reflects the needs for this age group. Patients were provided with a range of healthy lifestyle support including smoking cessation. The practice offered NHS health checks to patients including elderly health checks to patients who are 60 plus and not reached the age of 75. Appointments could be booked online in advance and a text message reminder system was in place to remind patients of pre booked appointments.

The practice provided contraception and sexual health service for patients and actively referred patients to specialist service such as genital-urinary medicine (GUM) and young people's sexual health service Brook.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. We saw the practice maintained a register of patients whom were vulnerable and patients with a learning disability to help ensure they received the required health checks and annual reviews. The practice offered longer appointments for people with learning disabilities and had access to easy read and pictorial information to enable patients to

Good



Summary of findings

engage during consultations. Care plans were in place for majority of patients with a learning disability or who were vulnerable; however there were no records of formal annual reviews of care taking place during 2014/15 for patients with a learning disability.

For patients where English was their second language, an interpreter could be arranged.

For patients requiring support with alcohol or substance misuse the community drug and alcohol team provided weekly clinics at the practice which patients could be referred.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). All staff within the practice had completed dementia awareness training and were able to identify the needs of people with dementia and where appropriate their carers. The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and voluntary organisations, including referrals to counselling services.

For patients who experienced difficulties attending appointments at busy periods they would be offered appointments at the beginning or end of the day to reduce anxiety.

Good



Summary of findings

What people who use the service say

During our inspection we spoke with seven patients. We reviewed two CQC comment cards which patients had completed leading up to the inspection.

The comments were positive about the care and treatment people received. Patients told us they were treated with dignity and respect and involved in making decisions about their treatment options.

Feedback included individual praise of staff for their care and kindness and going the extra mile. We reviewed the results of the GP national survey carried out in 2013/14 and noted 81% described their overall experience of this surgery as good and 81% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service **SHOULD** take to improve

The practice showed us how they monitored patient data, but were unable to provide evidence of full clinical audits taking place which demonstrated changes to patient outcomes.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks and annual reviews; however there were no records of reviews taking place during 2014/15 for those patients on the register.

The practice had a system in place for handling complaints and concerns; however there was no evidence of the system being put into practice.

Dr Kiren Kaur

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 specialist advisor and an expert by experience. Experts by Experience are members of the public who have direct experience of using services.

Background to Dr Kiren Kaur

Dr Kiren Kaur a single handed GP practice provides primary medical services in Oldham from Monday to Friday. The practice is open between 8.00am – 6.30pm Monday to Friday with appointments available with the GP 9:15am to 5:30pm most days. The practice does not have extended hours.

Dr Kiren Kaur is situated within the geographical area of NHS Oldham Clinical Commissioning Group (CCG).

The practice has a PMS contract. The Primary Medical Services (PMS) is a locally-agreed contract agreed between NHS England and the practice for delivering primary care services to local communities.

Dr Kiren Kaur is responsible for providing care to 2843 patients of whom, 49% were male and 51% were female. Patients are from the third most deprived decile with 6% black and minority ethnic (BME) patients.

The practice consists of one female GP, a nurse practitioner, nurse. A new practice manager was appointed in February 2015 supported by receptionists. From April 2015 the practice has appointed a health care assistant and was recruiting an additional salaried GP.

When the practice is closed patients were directed to the out of hours service.

Why we carried out this inspection

We inspected this service as part of our 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.

How we carried out this inspection

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 25th March 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with seven patients and five members of staff. We spoke with a range of staff, including the GP, new practice manager, Nurse Practitioner and reception staff.

We reviewed two Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

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

Detailed findings

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

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

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

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example the new practice manager had formalised the system for reporting significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Records were not available for 2014, however new practice manager had established systems to ensure information was effectively stored and shared with staff where appropriate.

A new system to report, investigate and act on incidents of patient safety had been put in place by the new practice manager, this included identifying potential risk. Staff we spoke with knew to report concerns and incidents.

We saw staff had access to multiple sources of information to enable them to maintain patient safety and keep up to date with best practice.

Learning and improvement from safety incidents

The practice had a new system introduced by the new practice manager for reporting, recording significant events, We saw from the practice significant events records and speaking with staff investigations had been carried.

There were records of significant events that had occurred during since February 2015 and we were able to review these. We reviewed significant events reported since February 2015 which had been recorded and saw that action had been taken, however as these were recent significant events, reviews had not yet taken place or dates set for action to be reviewed. No records prior to 2015 were available. Speaking with the new practice manager they were aware of improvements required and a system had been introduced which staff were familiar. Significant events were a standing item on the practice meeting agenda, there was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and

nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. All staff told us the practice was open and willing to learn when things went wrong.

Staff told us they received updates relating to safety alerts they needed to be aware of via emails. The nurse told us they received regular updates as part of their ongoing training, and self-directed learning and attending practice nurse forums.

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff explained to us where they had concerns they would seek guidance from the safeguarding lead or seek support from a colleague as soon as possible.

We saw the practice had in place a detailed child protection and vulnerable adult's policy and procedure. Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to ensure information was shared between staff to ensure continuity of care.

We spoke with the GP who was the safeguarding lead; they had completed training to level 3 in child protection. We were provided with examples of staff being the first to alert the relevant agencies of concerns about a child or vulnerable adult, notes were placed on patient's records and meetings were held with the local authority safeguarding team, health visitors, district nurses and school nurses where appropriate.

The practice linked with the Local authority, health visitors and district nurses to monitor vulnerable patients and attended where possible multi agency case conferences. Speaking with staff at the practice they were knowledgeable about the contribution the practice could make to safeguarding patients. We were provided with examples of where staff had been proactive in safeguarding patients and worked alongside health visitors and social workers. We noted staff were vigilant of patients who may be at risk of domestic violence, and where it was known a patient was a victim of domestic violence alerts were placed within patient's records.

A chaperone policy was in place, Speaking with staff who acted as chaperones, they were clear of the role and responsibilities.

Are services safe?

Medicines Management

The practice held medicines on site for use in an emergency or for administration during consultations such as administration of vaccinations.

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. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

We saw emergency medicines were checked to ensure they were in date and safe to use. We checked a sample of medicines and found these were in date, stored safely and where required, were refrigerated. Medicine fridge temperatures were checked and recorded to ensure the medicines were being kept at the correct temperature.

We saw an up to date policy and procedure was in place for repeat prescribing and medicine review. The practice worked alongside the clinical commissioning group, medicines management team who visited the practice to look at prescribing within the practice and audit medicines such as antibiotics and Benzodiazepines to support the practice in ensuring they are following up to date prescribing guidance.

Speaking with reception staff they explained to us the system in place to ensure where changes to prescriptions had been requested by other health professionals such as NHS consultants and/or

following hospital discharge, the changes were reviewed by the GP daily and the changes implemented in a timely manner. We were shown the safety checks carried out prior to repeat prescriptions being issued and where there were any queries or concerns these were flagged with the GP before any repeat prescriptions were authorised.

The practice maintained a register to track prescriptions received and distributed. This was kept separate from the prescription pads which were securely locked away. Prescription pads held by the GP were locked away. A nominated member of staff was responsible for prescription ordering and management of prescriptions.

We saw prescriptions for collection were stored behind the reception desk, out of reach of a patient. Reception staff we spoke with were aware of the necessary checks required when giving out prescriptions to patients who attended the practice to collect them, i.e. date of birth, address of patient.

Cleanliness & Infection Control

The practice was found to be clean and tidy. The GP took the lead for infection control and audits were carried out by the local clinical commissioning group.

Cleaners were employed by a building management team who attended every day. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis, however a schedule for deep cleaning of carpets was not evident. The practice manager told us they would follow this up and request a schedule be put in place if one did not already exist. We looked in several consulting rooms. All the rooms had hand wash facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly, however consulting rooms used by nursing staff were carpeted, Good practice suggests carpets should not be used in treatment and minor surgery rooms. The flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. We raised this with the practice manager who told us they have ask the buildings management team to replace to more suitable flooring, but to date they have not agreed to do this.

We saw the dignity curtains in each room were disposable and were clearly labelled as to when they required replacing.

All the patients we spoke with were happy with the level of cleanliness within the practice.

We saw up to date policies and procedures were in place. The policy included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

All staff we spoke with were clear about their roles and responsibilities for maintaining a clean and safe environment. We saw staff had received infection control training. We saw rooms were well stocked with gloves, aprons, alcohol gel, and hand washing facilities.

Are services safe?

The practice only used single use instruments, we saw these were stored correctly and stock rotation was in place.

Equipment

The practice manager had a plan in place to ensure all equipment was effectively maintained in line with manufacture guidance and calibrated where required. We saw maintenance contracts were in place for all equipment.

All staff we spoke with told us they had access to the necessary equipment and were skilled in its use.

Checks were carried out on portable electrical equipment in line with legal requirements.

The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Staffing & Recruitment

There were formal processes in place for the recruitment of staff to check their suitability and character for

employment. The practice had a recruitment policy in place which was up-to-date. We looked at the recruitment and personnel records of three staff. We saw recruitment checks had been undertaken. This included a check of the person's skills and experience through their application form, personal references, identification, criminal record and general health. We were satisfied that Disclosure and Barring Service (DBS) checks had been carried out appropriately for all clinical staff to ensure patients were protected from the risk of unsuitable staff.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performer's list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practice.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice 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.

Identified risks were included on a risk log which included COSHH, reviewed the building management. All health and safety information was available to practice staff at the main reception.

The practice manager had clear staffing levels identified and procedures in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness; this was recorded within the business continuity plan. Staff told us as they were a small team, they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff.

Arrangements to deal with emergencies and major incidents

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

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

We saw emergency procedures for staff to follow if a patient informed staff face to face or over the telephone if they were experiencing chest pains, this included guidance from the Resuscitation council and calling 999 for patients where required. Staff were able to clearly describe to us how they would respond in an emergency situation.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the building management, CCG and associated health and social care professionals.

Records showed that staff were up to date with fire training and regular fire drills were carried out.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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 ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and nurse practitioner that they completed thorough assessments of patients' needs in line with NICE guidelines.

Speaking with the nurses practitioner they explained to us how they and the practice nurse reviewed patients with chronic diseases such as asthma on an annual basis, we saw from The national Quality Outcome Framework (QOF) 2013/14 showed, 100% of the outcomes had been achieved for patients with asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average, however the practice fell below local and national average outcomes for patients with diabetes and Hypertension.

Data provided from QOF 2013/14 suggested that patients at risk of hypertension who required annual blood pressure checks were not routinely having blood pressures checked or ambulatory blood pressure monitoring (ABPM) to confirm a diagnosis of hypertension. Speaking with the GP and nurse practitioner they told us they opportunistically checked patients' blood pressure and with the introduction of a new health care assistant from April 2015 sought to improve on this outcome enabling more systematic monitoring of patients' blood in line with NICE guidance to confirm or discount a diagnosis of hypertension.

We saw the practice maintained a register of patients with a learning disability to help ensure they received the required health checks and annual reviews; however there were no records of reviews taking place during 2014/15 for those patients on the register.

The GP or nurse practitioner carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis as a way of monitoring their physical health and providing health improvement guidance. The QOF 2013/14 provided evidence the practice

were responding to the needs of people with poor mental health, above the average of the local CCG, by ensuring for example they had a comprehensive care plan documented in the record and patients had access to health checks as required such as, a record of alcohol consumption and body mass index (BMI) in the preceding 12 months.

We saw from QOF that 100% of child development checks were offered at intervals that were consistent with national guidelines and policy.

We saw from information available to staff and by speaking with staff, that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts they needed to be aware of via emails and the nurse practitioner told us they received regular updates as part of their ongoing training and attending monthly practice nurse forums whenever possible.

Clinical staff were able to clearly describe to us how they assessed patient's capacity to consent in line with the Mental Capacity Act 2005.

The practice worked within the Gold Standard Framework for end of life care, where they held a register of patients requiring palliative care. Multi-disciplinary care review meetings were held with other health and social care providers.

We were told for patients where English was their second language interpreter could be booked in advance. This was in line with good practice to ensure people were able to understand treatment options available.

Management, monitoring and improving outcomes for people

Speaking with clinical staff, we were told assessments of care and treatment were in place and support provided to enable people to self-manage their condition, such as diabetes or Chronic obstructive pulmonary disease (COPD). Assessments were carried out for patients with COPD and where required seasonal adjustments were made which included prescribing rescue medication to help when a patients was experiencing exacerbation.

A range of patient information was available for staff to give out to patients which helped them understand their conditions and treatments.

Are services effective?

(for example, treatment is effective)

Staff said they could openly raise and share concerns about patients with colleagues to enable them to improve patient's outcomes.

The practice showed us how they monitored patient data, but were unable to provide evidence of full clinical audits taking place which demonstrated changes to patient outcomes. Clinical Audit is a process or cycle of events that help ensure patients receive the right care and the right treatment.

The practice used the information they collected for the Quality and Outcomes framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients with long term health conditions such as, asthma and for patients with Chronic obstructive pulmonary disease (COPD) above the local CCG and national average, however the practice fell below local and national average outcomes for patients with diabetes and Hypertension.

The practice was also ensuring childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 96.1% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination.

Information from the QOF 2013-2014 indicated the practice had maintained a level of achievement with 92% of outcomes achieved just below the local and national average.

Patients told us they were happy the doctor and nurses at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw evidence staff had attended mandatory courses such as annual basic life support, additionally all staff had completed dementia awareness training. We noted a good skill mix among the doctor and nurses with a number having additional training and qualifications. The GP was up to date with their yearly continuing professional development requirements. The GP was revalidated in 2013 (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 practice and remain on the performers list with NHS England).

Speaking with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively, however we noted the GP required updates in some areas including cervical cytology and minor surgery. The GP informed us they areas which required updating would form part of the continuing professional development during 2015.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training for example NHS health checks and mental health.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and treating minor ailments. The nurse practitioner had an extended role to see and treat patients with minor ailments and was able to prescribe a range of medicines including antibiotics. Speaking with the nurse practitioner and looking at training records we saw that they had appropriate training to fulfil the enhanced roles.

All staff we spoke with told us they were happy with the support they received from the practice. Staff told us they were able to access training and received updates. We saw the nurse had access to training as part of their professional development, attending training and practice nurse events in which updates on key issues was provided.

Working with colleagues and other services

We found staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. Multi-disciplinary meetings took place on a monthly basis. Communication on a daily basis with community midwives, health visitors and district nurses who were based within the same building or via telephone and fax.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge

Are services effective?

(for example, treatment is effective)

summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP took the lead responsibility for reading and acting on any issues arising from communications with other care providers on the day they were received, and disseminating to appropriate staff for action such as reception staff to arrange appointments or home visits. All staff we spoke with understood their roles and felt the system in place worked well.

For patients at the end of life the practice worked closely with the Macmillan and district nurse to ensure co-ordinated care was in place. Patients who required emotional support would be referred to counselling and bereavement support services

For patients requiring support with alcohol or substance misuse the community drug and alcohol team provided weekly clinics at the practice which patients could be referred.

Information Sharing

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

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

The GPs described how the practice provided the 'out of hours' service with information, to support, for example 'end of life care.' Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care (EoLC), where they provided a summary care record and EoLC information to be shared with local care services and out of hour providers.

For the most vulnerable 2% (a nationally agreed percentage) of patients over 75 years of age, and patients with long term health conditions, information was shared routinely with other health and social care providers to monitor patient welfare and provide the best outcomes for patients and their family.

Consent to care and treatment

A policy and procedure was in place for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations.

We found that staff were aware of the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, this included best interest decisions and do not attempt resuscitation (DNACPR). There were policies and procedure in place for staff to refer with regard to the Mental capacity Act 2005 (MCA). Staff told us where they had concerns about a patient's capacity; they would refer patients to the GP.

All staff we spoke with made reference to Gillick competency when assessing whether young people under sixteen were mature enough to make decisions without parental consent for their care. Gillick competency allows professionals to demonstrate they have checked the person understands of the proposed treatment and consequences of agreeing or disagreeing with the treatment. The practice had a Gillick competencies checklist for staff to refer to if they were unsure about the process to follow. Speaking with the practice nurses they routinely saw young people unaccompanied and used the Gillick competency to assess their understanding. Where capacity to consent was unclear they would seek guidance prior to providing any care or treatment.

Health Promotion & Prevention

New patients looking to register with the practice were able to find details of how to register on the practice website or by asking at reception. New patients were provided with an appointment for a health check.

Are services effective?

(for example, treatment is effective)

The practice had a range of written information for patients in the waiting area, including information they could take away on a range of health related issues, local services health promotion and support for carers.

We were provided with details of how staff promoted healthy lifestyles during consultations. The

clinical system had built in prompts for clinicians to alert them when consulting with patients who smoked or had weight management needs. We were told health promotion formed a key part of patients' annual reviews and health checks.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 113 patients were offered checks of which 90 took up the offer of the health check. The practice followed the guidance from the local CCG to ensure patients followed in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The nurses provided lifestyle advice to patients this included, dietary advice for raised cholesterol, alcohol screening and advice, weight management and smoking cessation. Patients could be referred to 'Choose to change' a community public health service specifically for support with weight management.

Patients newly diagnosed with diabetes were referred to specialist education programme to support patients self manage their condition and maintain a healthy lifestyle.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved 76% vaccination rate for the influenza vaccine for those over 65, just above the local average and above average for children aged two, three and four years old, for example 52% of two years old compared to a local average of 34%.

A children's immunisation and vaccination programme was in place. Data from NHS England showed the practice was achieving high levels of child immunisation including the MMR a combined vaccine that protects against measles, mumps and rubella, Hepatitis C and Pertussis (whooping cough). We saw from QOF 100% of child development checks were offered at intervals that are consistent with national guidelines and policy. There was a clear policy for following up non-attenders by the practice nurse.

The practice's performance for cervical smear uptake was 84%, which was higher than the local and national averages. There was a policy to follow up those who did not attend.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, the reception staff would pass onto the GP and where any follow up was required staff would arrange an appointment or home visit.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying where possible to meet people's needs.

We spoke with seven patients and reviewed two CQC comment cards received the week leading up to our inspection. All were positive about the level of respect they received and dignity offered during consultations.

The practice had information available to patients in the waiting area and on the website that informed patients of confidentiality and how their information and care data was used, who may have access to that information, such as other health and social care professionals. Patients were provided with an opt out if they did not want their data shared.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and waiting area, which helped keep patient information private.

We observed staff speaking to patients, with respect. We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us when patients arriving at reception wanted to speak in private; they would speak with them in one of the consultation rooms at the side of reception. Majority of patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff. Looking at the results from the GP national survey, 80% of respondents found the receptionists at this surgery helpful.

Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones, modesty sheets to maintain patient's dignity.

We found all rooms had dignity screens or lockable doors in place to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

The patients told us they were happy to see the GP or the nurse as they felt all were competent and knowledgeable.

Patients we spoke with told us the GP and the nurses were patient, listened and took time to explain their condition and treatment options. The results from the GP national survey showed 95% said the last nurse they saw or spoke to was good at giving them enough time, 87% said the last nurse they saw or spoke to was good at involving them in decisions about their care and 81% had confidence and trust in the last GP they saw or spoke to.

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 88% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate; this was above the local and national average.

The practice had formal care plans in place for 2.5% of patients; they included care plans for vulnerable patients over 75 year of age, patients with poor mental health and those patients at risk of unplanned hospital admissions.

We noted where required patients were provided with extended appointments for example reviews with patients with learning disabilities or multiple conditions to ensure they had the time to help patients be involved in decisions.

Patient/carers support to cope emotionally with care and treatment

All staff we spoke to were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

From the GP national survey 75% of respondents stated the last GP they saw or spoke to was good at listening to them, 76% say the last GP they saw or spoke to was good at giving them enough time and 95% say the last nurse they saw or spoke to was good at giving them enough time.

The practice had identified within their patient population a number of patients who were carers and had carers established a carer's register. We saw information for carers was readily available in the waiting area and on the practice website.

Are services caring?

Patients who were receiving care at the end of life were identified and joint arrangements were put in place as part of a multi-disciplinary approach with the palliative care team. Bereaved patients were referred to a counselling service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice worked with patients and families and in a joined up way with other providers in providing palliative care and ensuring patient's wishes were recorded and shared with consent with out of hours providers at the end of life.

The practice made reasonable adjustments to meet people's needs. Staff and patients we spoke with provided a range of examples of how this worked, such as, opportunistic screening and reviews, accommodating home visits, booking extended appointments and arranging translators.

We saw where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or requesting repeat prescriptions with staff at the reception desk. We saw patients accessing repeat prescriptions at reception without any difficulties.

The practice did not have a patient participation group but this was a priority for the Practice in 2015.

Tackling inequity and promoting equality

The practice had taken steps to ensure equal access to patients, the website was accessible, and could be translated into different language if required.

The practice was over two floors with the reception desk on the ground floor, waiting area and consultation rooms of the first floor accessible via a lift or stairs. The practice was accessible for patients with disabilities and had disabled parking spaces available. A disabled toilet was available as were baby changing facilities. A hearing loop had been installed within the practice to support patients who were hard of hearing.

Translation services were available for patients and staff were familiar with how the service worked.

The practice provided extended appointments where necessary and appointments were available until 5:30 pm with the GP on Tuesday, Wednesday, Thursdays and 8:30am with the nurse practitioner Monday's and Thursday's. Late evening appointments were not available due to restricted opening times of the building.

Access to the service

The practice is open between 8:30am and 6pm Monday to Friday with appointments available with the GP from 9:15am and 5:00pm Monday's and Fridays and 9:15am to 5:30pm Tuesday, Wednesday and Thursday. Appointments with the nurse practitioner or practice nurse were available Monday to Friday. Patients were able to make appointments in advance, in person at reception or by telephone. On the day emergency appointments were available by telephoning the practice at 8:00am. Where all appointments were filled, reception staff would take patients details which would be followed up by the GP or nurse practitioner and where required same day appointments or telephone consultations would be arranged.

We saw all children under five would be seen on the day as would vulnerable patients either by telephone consultation of appointments at the practice. We saw evidence of this taking place, with alerts placed on patients records to alert reception staff of the need where required to offer same day appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Home visits were available for patients each day by telephoning the practice.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed, this information was detailed on the practice website and included information on the urgent care centre which could treat minor injury or illness. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for patients who needed them for example those with long-term conditions, patients with learning disabilities or patients who required a translator. This also included appointments with a named GP or nurse.

The majority of patients we spoke with were satisfied with the appointment system. We saw from the GP national survey 90% of respondents find it easy to get through to this surgery by phone, above the local average, 85% were able to get an appointment to see or speak to someone the last time they tried and 96% say the last appointment they got was convenient

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns; however there was no evidence of the system being put into practice. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the new practice manager was to take on the role of responsible person who handles all complaints in the practice. There were no clear

records of how previous complaints had been managed, and the GP did not have evidence of the handling of existing complaints in line with the practice policy. We raised this with the GP and new practice manager who told us they would ensure a central record of all existing investigation would be put in place and the practice manager would take on the responsibility for ensuring complaints were managed appropriately in the future and where relevant share learning and outcomes with staff through team meetings. We did see evidence of where complaints required a referral to external bodies such as the Medical defence union or ombudsman this had been done.

We saw complaints information was available to patients in the waiting area, within the practice leaflet and via the website. The information also provided details of the Patient Advice and Liaison Service (PALS).

Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

Are services well-led?

Good 

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's mission statement. The practice mission statement was, 'The high quality of health care we provide will be backed by efficient and effective service, responsive to patient demand and accessible to all.' We saw this demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with five members of staff and they all expressed their understanding of the core values, and we saw evidence of the latest guidance and best practice being used to deliver care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at several of the policies and saw these were up to date and reflected current guidance and legislation, the new practice manager told us they were in the process of systematically reviewing all policies and procedure to ensure they were up to date with current guidance.

There was a new leadership structure developing following the retirement of the practice manager and appointment of the new practice manager in February 2015. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw the practice made use of data provided from a range of sources including the Clinical Commissioning group (CCG), General Practice Outcome Standards (GPOS) and the national patient survey to monitor quality and outcomes for patients such as services for avoiding unplanned admissions.

The practice used the range of data available to them, using the data to improve outcomes for patients and work with the local CCG. The practice also used the Quality and

Outcomes Framework (QOF) to measure their performance. The QOF 2013/14 data for this practice showed it was performing in line with national standards achieving 91.1% of outcomes, just below the local and national average.

The new practice manager and GP met on a regular basis to discuss practice issues, practice developments and the GP and nurse practitioner met weekly to discuss clinical issues. Full staff meeting took place monthly and these were minuted, the new practice manager planned to rotate the day of the meetings to ensure part time staff could attend meetings more regularly. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

From the summary of significant events which the new practice manager had introduced we saw incidents had been recorded and saw that action had been taken, however as these were recent significant events we saw no evidence of reviews taking place or dates set for action to be reviewed. No records prior to 2015 were available. Speaking with staff and reviewing recent minutes of staff meetings we saw learning had taken place and actions discussed.

The practice did not carry out full clinical audits; however this was an area both the GP and new practice manager were aware needed to be addressed as a priority.

The practice had arrangements for identifying, recording and managing risks. The practice manager provided us with details of the maintenance and equipment checks which had been carried out in the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufacture guidelines. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Leadership, openness and transparency

Team meetings took place once a month within the practice and these were minuted. The GP and Nurse practitioner met weekly to discuss clinical issues. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with GPs or the practice manager, staff told us there was never a time when there was no one to speak to seek support, advice or guidance.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies and procedures, for example, a recruitment policy and

Are services well-led?

Good 

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

induction programme were in place to support staff. We were shown the staff handbook that was available to all staff, this included sections on health and safety, equality, leave entitlements, sickness, whistleblowing and bullying and harassment. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the national patient survey, The NHS friends and family test, compliments and complaints.

We saw that there was a complaints procedure in place, with details available for patients in the waiting area, practice leaflet and on the website, however there was no evidence of the system being put into practice. There were no clear records of how previous complaints had been managed, and the GP did not have evidence of the handling of existing complaints in line with the practice policy. We raised this with the GP and new practice manager who told us they would ensure a central record of all existing investigation would be put in place.

We reviewed the results of the GP national survey carried out in 2013/14 and noted 81% described their overall experience of the practice as good.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The new practice manager had prioritised establishing a patient participation group in 2015 as an additional means of engaging patients in practice development and seeking patient feedback.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three 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 development opportunities.

The practice had reviewed significant events and other incidents and shared with staff informally.