

Dr Shambhu Singh

Quality Report

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Date of inspection visit: 22 October 2014

Date of publication: 05/02/2015

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Dr. Shambhu N Singh's surgery. Our comprehensive inspection was a planned inspection, which took place on 22 October 2014. This practice had not been inspected before.

We rated this service overall as good. Patients were complimentary about the care and treatment they received at this practice and spoke positively about all the staff working there.

Our key findings were as follows:

- Patients could always get an appointment when they wanted one and had no difficulty in contacting the surgery.
- Patients were very satisfied and were complimentary about the service they received from their family GP in this small surgery in the heart of a settled community.
- Patients were treated with courtesy and respect and involved in their diagnosis and treatment choices.

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

Importantly, the provider must:

- Ensure that patients are protected by gathering and reviewing the information in relation to people working at the practice as required by the regulations of the Health and Social Care Act 2008. This concerns the recruitment of staff and the personnel information required including proof of identity, qualifications, employment history and relevant Disclosure and Barring Checks (DBS). Checks are carried out, if necessary to the role, and the relevant information retained as required by the legislation.

In addition the provider should:

- Formalise in writing the range of governance protocols applicable in the practice.
- Consideration should be given to the time available to the part time practice manager to action the managerial functions in the practice.

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?

We have rated this service as requires improvement. The provider did not have adequate arrangements to ensure the recruitment procedures were in line with legislation to ensure necessary employment checks were in place for all staff. Key documentation was missing from staff files to demonstrate their fitness to work at the practice including proof of identity, qualifications, employment history and relevant Disclosure and Barring Checks (DBS) for clinical staff and the relevant information retained as required by the legislation.

Professional healthcare staff ensured that they were up to date with the most recent national and professional advice for treatment and care. Emergency equipment and medicines were available and correctly maintained.

Staff had received regular updated training in how to respond to medical emergencies.

Staff took action to safeguard adult and child patients and when appropriate made safeguarding referrals using clearly defined protocols. A range of effective hygiene and infection control measures were in place.

Requires improvement



Are services effective?

We have rated the practice good for effective. The doctor and nurse were trained and up to date. Opportunities had been provided for staff training. The GP made use of audits and evaluations to help maintain and improve clinical outcomes for patients.

All staff had regular, though generally informal, supervision and a documented annual assessment of their performance.

Good



Are services caring?

The practice is rated as good for caring. Patient survey data and the patients we heard from rated the practice higher than others for several aspects of care this included appointment times and home visits. Patients said all staff treated them with compassion, dignity and respect. Patients also said that staff were sensitive and supportive. Patients felt actively consulted and involved in care and treatment decisions affecting them or people close to them. They felt empowered to manage their own health, care and wellbeing which helped them to maximise their independence. Accessible information was provided to help patients understand the care available to them.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for responsive. Patients reported good access to the practice and continuity of care with the GP in the single GP practice. Appointments were readily available and home visits made to patients who requested them. The practice took opportunities to provide holistic medical care and to facilitate health promotion and undertook screening for conditions in order to promote early diagnosis or interventions as necessary.

The services which the practice delivered took into account people with complex needs for example those living with dementia.

Good



Are services well-led?

The practice is rated as good for well-led. There was a clear vision set by Dr Singh in respect of staff roles, responsibilities and training in order to deliver and further develop the service. Staff were clear about their varied responsibilities in this small practice. Staff felt supported by the doctor and practice manager and all staff spoke of their appreciation of each other's roles and their personal commitment to a small team. Staff had received training and their views were sought and valued by the doctor leading the practice.

Good



Summary of findings

What people who use the service say

Information from the 2013 patient survey completed by 40 patients gave good feedback saying:-

I am confident about this doctor's ability to provide care:
97.5%

I would be completely happy to see this doctor again:
100%

Was this visit with your usual doctor?
100% Yes

On the day of inspection we asked patients what they thought was good about the practice. Patients were very complimentary about the standard of care and treatment they received. They told us they could easily get an appointment with the doctor or nurse at a time which suited them.

We spoke with five patients and received 23 completed CQC comment cards. These comments were very complimentary. Comments included: how pleased patients were with the clinical staff and how pleased they were to have one family doctor. There were positive comments about the helpful reception staff and comments spoke of overall satisfaction or praise with the practice. Many had been with the practice for a number of years and would not want to go anywhere else.

These comments were received from males and females and that they included patients who had experience of mental health issues, mother and baby services, and had long term conditions such as diabetes. Patients told us they felt listened to and were actively involved in planning their care and treatment. They told us they were treated with dignity and respect.

Areas for improvement

Action the service MUST take to improve

The information contained in the staff records was not adequate and did not comply with the legal requirements. The provider must ensure that patients are protected by gathering and reviewing the information in relation to people working at the practice as required by the regulations of the Health and Social Care Act 2008. This concerns the recruitment of staff and the personnel information required including proof of identity, qualifications, employment history and relevant Disclosure and Barring Checks (DBS). Checks are carried

out, if necessary to the role, and the relevant information retained as required by the legislation. This applies to non clinical staff employed in the practice and also to locum doctors working at the practice.

Action the service SHOULD take to improve

- Formalise in writing the range of governance protocols applicable in the practice.
- Consideration should be given to the time available to the part time practice manager to action the managerial functions in the practice.

Dr Shambhu Singh

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP and a practice manager.

Background to Dr Shambhu Singh

The surgery run by Dr Singh is located in Queens Drive in Mossley Hill which is itself a settled residential area in South Liverpool. The practice has operated from a former semi-detached house since 1941 and some patients have been attending the surgery from that time.

The practice serves 1570 patients in a community with health challenges including those brought about by age and by disability. The practice is run solely by Dr Shambhu Singh who has been at the surgery throughout his career as a GP. He is helped and supported by a team of wholly part time staff which includes a nurse, a practice manager and four administrative staff who have been working in the practice between 15 and 30 years.

The practice offers medical services under a General Medical Services (GMS) contract. All patients are seen in surgery within 24 hours, urgent cases are seen the same day. All children are seen the same day.

The practice seeks to be proactive in taking preventative measures to detect early symptoms of disease and carries out health checks and blood tests as opportunities arise. Lifestyle advice is also given.

The practice is an undergraduate student training practice for Liverpool Medical School and has been so for many years.

Out of hour's service are provided by Urgent Care 24.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 October 2014. During our inspection we spoke with a range of staff (doctors, nurse, receptionists and manager) and spoke with patients who used the service. We reviewed comment cards where patients 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:

- 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

Detailed findings

- 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 evidenced that it recorded and analysed a range of safety audits. These covered analysis of clinical practice or of services offered. Significant event analysis (SEA) had been carried out and documented. Consideration had been given to national patient safety alerts and feedback from patients. The outcomes of such analysis evidenced lessons learned and changes were implemented accordingly such as improved communication within the practice.

Arrangements were in place to identify patients who required annual reviews of on-going care and treatment to ensure it continued to be safe and effective.

Staff told us that they could raise any concerns with the doctor or with the practice manager directly. They could also raise concerns through their meetings. For example, staff could also report any matters of safety concerns. Therefore Processes were in place which enabled reporting to external agencies if appropriate.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. Significant event reviews were undertaken regularly. We looked at a representative sample of recorded significant events or incidents covering a four month period. Significant alerts were examined by the doctor. If outcomes or events were not as anticipated, patients were involved in feedback as were any other relevant staff and a record kept. These records enabled the single handed practice to keep a consistent and transparent approach to processes. This contributed to a cycle of continual improvement and lessons learned were recorded.

Reliable safety systems and processes including safeguarding

Everyone we spoke with who was working at the practice had a good understanding of safeguarding issues. All members of the team at Dr Singh's surgery knew about the systems, processes and practices which were essential to keep adults and children safe. All staff had received training appropriate to their role. Dr Singh was the safeguarding lead and was correctly trained for adult safeguarding and for working with children, young people and/or their parents/carers. The level of training for adults

and children was appropriate. This is sometimes called level three training as it is for professionals who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

A chaperoning policy was in place and arrangements clearly made known to patients.

Medicines management

There was a process in place for prescribing and reviewing prescription medicines. We saw that repeat prescriptions could be obtained by patients when necessary in a timely way. Medicine audits were up to date and clear. Useful patient information about medicines was supported by information leaflets in the waiting room. All prescriptions were signed by the doctor and blank prescription forms were handled in accordance with national guidance and kept securely at all times. Patients issued with repeat prescriptions were reviewed at least once a year as a minimum. Those deemed as a higher risk were reviewed more frequently.

Some emergency medications were available in the practice and were stored and managed correctly.

We looked at records to see if medicines requiring refrigeration had been stored appropriately. Records had been completed and showed these medicines had been held within the accepted temperature range, and so were safe to administer. Vaccinations were also kept correctly and within manufacturers guidelines for the storage of vaccines.

Cleanliness and infection control

The practice had identified a named person who had lead responsibilities for cleanliness and the management and audit of infection control measures. We spoke with staff who told us they were trained in infection control processes.

There were sufficient hand washing facilities and alcohol gel available throughout the premises. There were sufficient quantities of gloves and aprons available. The consulting couches had paper rolls protecting them.

The premises were visually clean and tidy throughout. There had been no reported incidents from sharps injuries or spillage.

Are services safe?

We saw evidence of systems, policies and training for cleaning, infection prevention and control. Quality assurance systems (sometimes called governance) needed more structure in order to enable audits to be conducted.

We saw clinical and other waste was managed appropriately.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. Records were kept confirming all equipment in use was correctly maintained and was safe for use.

Equipment required for resuscitation or other medical emergencies was available and was readily accessible for urgent use. Personnel had been trained and staff had sufficient support and knew what to do in urgent and emergency situations. There was no defibrillator. According to current external guidance and national standards, practices should risk assess the emergency response process to determine if defibrillators would be needed.

Oxygen was not kept. It would be best practice to have oxygen available and a revised medical emergencies protocol. Oxygen is considered essential in dealing with certain medical emergencies. The National Resuscitation Council has said: 'Current resuscitation guidelines emphasise the use of oxygen, and this should be available whenever possible.'

Staffing and recruitment

We looked at the arrangements for recruitment and for obtaining appropriate information about staff working at the practice. We talked to staff about how they had been recruited. Some staff had worked at the practice for over 10 years. They told us how they had applied for their posts through word of mouth or local job advertisements. The practice had spoken to previous employers in order to find out if their conduct had been satisfactory. They had then undergone an interview at the practice.

We talked to the practice manager about recruitment process and checked all five staff files. There is a legal requirement which sets out for providers all the

information which should be obtained and recorded for staff working in the service. This required information was not present in all of the staff files. For example, when we looked at the staff files we did not see photographs, proofs of identity and health checks. The practice manager told us that reception / administrative staff working in the practice did not have Disclosure and Barring Service (DBS) checks at all and that they were not needed for these staff. However, there was no practice policy in place at the time of inspection or individual assessments in relation to DBS and non – clinical staff. There were no DBS checks for the locum doctors or the practice nurse. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

There were sufficient numbers of doctor and nurse sessions for the size of this practice. There was a sufficient number of administrative staff because those duties were covered by the part time practice manager. The practice manager's time in providing cover for administrative duties significantly reduced the time available to carry out the managerial role.

Monitoring safety and responding to risk

The doctor in this small practice had provided a flexible and personalised service to patients who he had come to know clinically over many years. As patients had become older and more vulnerable the doctor had maintained home visits to patients as necessary. On the day of inspection we saw influenza injections being promoted by staff to patients in at risk groups and older patients who chose to have their influenza injection at home were visited by the doctor. He took such opportunities to undertake assessments, reviews, annual health checks and monitoring of patients conditions and successful outcomes were measure and recorded in the practice data.

Arrangements to deal with emergencies and major incidents

An up to date outline contingency plan was available and staff had access to each other's telephone number in this small practice. Staff were aware that having a plan in place meant that the practice was able to cope with a range of emergency or untoward events including power cuts and adverse weather conditions.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

In this small single handed GP practice the doctor had developed a personal knowledge of patients over a number of years. Patients were reassessed at each appointment and patients with long term conditions had their care and treatment managed directly by the GP. The doctor has kept his clinical knowledge up to date and also wider knowledge of best practice through the process of revalidation

The GP, locum GP and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

There were systems in place to ensure referrals to secondary care were made in line with national standards.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. For example, drug management and a heart condition known as 'atrial fibrillation' which resulted in some of the patients in that group benefiting from coming off regular medication as it was no longer needed. They carried out another audit for drug management and the heart condition with a further assessment of prescribed medication.

The GP and practice nurse worked together to ensure that they monitored patient activities and that together they were able to improve patient's outcomes for example in relation to lifestyle choice affecting health or long term conditions such as diabetes. The practice used the quality and outcomes framework (QOF) to assess its performance in addition to the regular clinical audits as illustrated above. Patient's care and treatment outcomes were monitored and the outcomes were benchmarked against the local clinical commissioning group (CCG) and also against national comparators.

Effective staffing

Practice staffing included doctor nurse, practice manager and administrative staff. All staff had access to an e-learning and the practice made use of a protected learning session once a month as facilitated by the clinical commissioning group (CCG).

The doctor and nurse were able to evidence that they were up to date and, where necessary, had revalidated their registrations and so were fully eligible to practice. The nurse had a programme of training and development in place which would continue to extend the number and type of long term conditions she would have responsibilities for.

Where roles had developed or extended appropriate training had been provided. Learning needs were identified through a system of annual appraisal.

As the practice was small much of the one to one supervision, though frequent through the year was informal and not documented. Annual appraisals were formal and were documented. Peer support was in evidence at the practice and clinical supervision was delivered through the management structure. The doctor and nurse demonstrated that they reflected personally and were able to liaise with other professionals outside the practice or within the clinical commissioning group (CCG) to reflect on the delivery of effective care and treatment in order to secure a cycle of continuous improvement.

The practice manager had to provide much of the in-house cover for administrative staff leave and absence and had little opportunity for her own continuing development.

Working with colleagues and other services

The practice had systems in place to deal with incoming post. Systems were in place for important information such as incoming blood tests ensuring that they were promptly reviewed. There were processes in place to ensure other services were quickly notified of events which would impact or affect patient care, for example updating the out of hour's service in relation to patients receiving or needing palliative care.

The practice had information in relation to bereavement which was to help families and friends.

Are services effective?

(for example, treatment is effective)

Information sharing

There were arrangements in place for the doctor to follow up any patients that had been referred to other services or discharged from hospital.

The practice had systems in place to ensure that the doctor and practice nurse communicated with patients to keep them informed. There was opportunity for patients to use the 'choose and book' system. Its use and uptake were monitored.

The practice attended the neighbourhood meetings organised by the clinical commissioning group (CCG). This forum provided an opportunity to the practice to reflect on such things as referrals and to encourage the delivery of 'joined up services' for patients.

Day to day communication with the out of hour's provider was recorded and timely. Practice staff brought forward all relevant alerts to the attention of the GP.

Staff were updating patient records and patient information correctly and they ensured that there was proper update of information between different electronic and paper-based systems, for example in relation to test results.

Consent to care and treatment

The GP, locum GP and nurse we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. When necessary carers were involved in supporting patients to understand why their consent was needed.

When providing care and treatment for children and young people assessments of capacity to consent were carried out in line with relevant guidance and staff had a clear understanding of Gillick competencies. (These help healthcare professionals to identify children aged under 16 who have the capacity to consent to medical examination and treatment).

Health promotion and prevention

The doctor explained to us how he took advantage of each contact with patients as an opportunity to promote health and prevent illness. These 'opportunistic events' were a key part in the doctor's approach to managing assessments and providing advice. The patient's waiting room held a wide selection of health promotion information and advice leaflets.

On the day of inspection reception staff were busy telephoning older and other at risk patients to check with them if they were going to have their influenza injection. Many said they were going to have their influenza injection and at least one older patient said that she would have the injection, but would prefer to have it at home. Arrangements were made for the doctor to visit that patient at home on a day and time as directed by the patient.

Any new patients were offered an initial health check. Health checks were also offered to patients aged 40 to 74 years of age. A health trainer visited the practice once a week.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff explained to us how they had received training to support them to deal sensitively with patients and respond to concerns. During our visit saw how well reception staff welcomed patients. They were familiar with all the patients who attended during the day.

We reviewed the most recent GP Patient Survey data available for the practice on patient satisfaction. Of the 107 patients who replied;

- 91% said the last GP they saw or spoke to was good at treating them with care and concern.
- 96% had confidence and trust in the last GP they saw or spoke to.
- 81% say the last GP they saw or spoke to was good at involving them in decisions about their care.

In the two weeks before our visit we invited patients to completed comment cards to provide us with feedback on the practice. We received 23 completed CQC cards, all of which were positive about the practice, the doctor and the staff. Patients said they felt the practice offered an excellent service. Comments included references to staff that were described as kind, helpful, thoughtful and caring. We also spoke with five patients during our inspection. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Patients requiring intimate examinations were offered a chaperone. This service was usually carried out by the nurse. Patient's privacy and dignity were maintained.

The reception staff area was separated from the patient's waiting area by a glass partition which helped keep patient information private. Given the constraints imposed by the building and layout of the reception area the staff endeavoured to ensure privacy was respected. Patients were also able to use the nurse's room for private conversations as necessary.

As a single GP practice the patients and their families were well known to the doctor. This meant that the doctor was well placed to involve as partners patients and those close to them in their care and to provide them with the emotional support they may need.

Care planning and involvement in decisions about care and treatment

In the CQC completed comment cards we saw that patients spoke positively about their involvement in planning and making decisions about their care and treatment. Patients told us the GP always sought and respected their views and was thoughtful and considerate in explaining the treatment options available. The feedback we received included comments from adult patients of different ages and patients with families, long term conditions and mental health problems all of whom had experience of treatment and care.

Patient/carer support to cope emotionally with care and treatment

The doctor explained to us how he recognised the support patients and carers might need to cope emotionally with their care and treatment. Staff also told us how they could support, or refer to support networks and self-help groups as necessary.

Where bereavement support was needed people were directed for further support by the practice to appropriate or specialist services such as the Liverpool Bereavement Service or the Alder Centre.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice did not have a patient participation group (PPG).

The practice had made use the quality outcomes framework (QOF) data in order to inform itself of its performance. The QOF percentage figure for the practice was 92% compared with 96% average for the local clinical commissioning group (CCG) area. However, we were told that this was due to some loss of data through migration to a new computer system and so the practice compared favourably with others in how it was succeeding in meeting local needs. The practice had used this information to plan its services and to deliver them in ways which respected individuals, coordinated care with other agencies and providers and promoted health and well-being. The practice regularly attended CCG led events including neighbourhood meetings and education events.

This single handed practice provided a personalised service to individuals and families that reflected the needs of the population served. Patients told us that they could always get appointments at convenient times and that the doctor made home visits to patients in need. We heard of a number of examples from older patients, or patient with long term conditions, including dementia, of how the GP had acted very promptly in making home visits to patients who were vulnerable or who had become suddenly unwell or who had experienced a fall or discharge from hospital. Any patients identified as developing any long term conditions were included into the appropriate register in the records in order that they could receive continuing support from the practice.

We reviewed the most recent GP Patient Survey data available for the practice on patient satisfaction. Of the 107 patients who replied;

- 96% of respondents with a preferred GP usually get to see or speak to that GP

CCG (regional) average: **58%**

- 93% of respondents usually wait 15 minutes or less after their appointment time to be seen

CCG (regional) average: **62%**

- 96% of respondents find it easy to get through to this surgery by phone

CCG (regional) average: **76%**

Tackling inequity and promoting equality

The practice was committed to ensuring equal opportunities for access to services and treatments to all patients and avoiding discrimination on the grounds of age, gender, disability, status, orientation, race or religion. The practice succeeded in making appointments available to meet the needs of patients. The doctor went out to older patients if they needed help or supervision in aspects of their care and treatment and were unable to attend the practice, for example in relation to the lung condition chronic obstructive pulmonary disease. There were long appointment opportunities for every patient on request or as required.

English was the first language for the majority of the practice population. Language Line translation services were available for those who spoke other languages. Clinical records identified patients with caring responsibilities as well as those being cared for so that staff were alerted to any special support or assistance they may need. Carers were given age and care related advice and support. Telephone appointments were available.

The services provided by the practice took into account patient's age disability and provided for pregnancy and maternity services and appointments reflected their needs. This was important to the practice even though the number of new births were very low, about 12 per year.

Access to the service

We found that all patients had timely access to appointments. This included initial assessment, diagnosis and treatment and on-going management of long term conditions. These appointments supported patients as individuals because of the ease of access to surgery based and home based appointments. All appointments and access to care and treatment were available at a time to suit them. This was supported by the GP Patient Survey where 100% said the last appointment they had was convenient.

The doctor provided telephone access and face to face appointments and had been able to prioritise his clinical time to see patients with the most urgent needs first without compromising surgery appointments. If patients

Are services responsive to people's needs?

(for example, to feedback?)

called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients

All services for patients were on the ground floor and were directly accessible as there was no need for steps or ramp.

The waiting area was large enough to accommodate patients with wheelchairs and prams. Toilet facilities were available for all patients attending the practice. Baby changing facilities were not available, but arrangements were easily made to use the nurse's room.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person to handle complaints in the practice. There was information available on display to patients. None of the patients spoken with had ever needed to make a complaint about the practice but felt confident that they would be free to openly discuss any concerns with their doctor.

There was one complaint recorded in the last year which was documented, recorded and actioned appropriately.

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

A vision and strategy were set out in the written statement of purpose for the practice. As a single GP practice Dr Singh has personally set out high standards for the practice to follow. The staff working at the practice had been with Dr Singh for many years, including those doctors who provided locum cover from time to time to cover any planned absence by Dr Singh. These staff had adopted the same patient centred vision established by him and implemented through the whole team. This philosophy has been embedded in a culture of care which has promoted good outcomes for patients. The regular reviews, audits, analyses of significant events, staff appraisals, team and clinical meetings had all worked together to deliver a visible leadership, focussing on the importance of quality care delivered to individual patients by their family GP with effective treatment outcomes for them.

Governance arrangements

There were systems in place addressing 'governance' in the practice, though these were not always clearly set out in writing and did rely on the GP and the practice manager. These systems included such things as management arrangements and personnel development and team performance meetings. Systems were in place in writing for analyses, the production and analysis of data. They ranged across the different aspects of the practice clinical and non clinical. This included a programme of clinical audit. Clinical audit offers clinicians the best way of assessing the quality of the care which they had given and which they should strive to give.

Thought had been given to assessments of quality, compliance with the most up to date guidelines and cost effectiveness.

As this was a small practice and so all staff were familiar with multi-tasking within their role. However, they were clear about their responsibilities and accountabilities.

Leadership, openness and transparency

Staff told us they were clear about the effective leadership in place and provided by Dr Singh. They said they were

supported and there was an open door culture. Staff told us they would be confident that any concerns or questions would be listened to by Dr Singh as staff safety and wellbeing was a priority. Staff said they were treated fairly.

Where meetings were documented the records indicated an open and communicative culture.

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

Staff told us they felt sufficiently involved in practice policies and were able to contribute to shaping the service and culture at the practice. The team had confidence in the leadership of the GP in this single handed and well led practice. Given that context they were uncertain about the practicality of a whistleblowing policy.

A wall mounted box was available in the waiting room. This was used by patients for repeat prescriptions and where patients sometimes left their suggestions.

The practice participated in the regular clinical commissioning group (CCG) neighbourhood meeting.

The practice had looked at the NHS national patient survey and the team were aware of it. The survey made many very positive comments about the practice and was available online. The practice did not have a patient participation group (PPG), but patients told us they felt so involved with and close to the practice and the GP that it was not a priority for them.

Management lead through learning and improvement

The doctor and the nurse told us that they had opportunities to maintain their clinical professional development through training and mentoring. Administrative staff felt appropriately trained to carry out their duties as led by the practice manager. Electronic learning was available in the practice.

All staff were part time and received a formal annual appraisal and on-going, though informal, supervision throughout the year with consideration given to any on-going training needs as incurred with the introduction of the computer system.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider did not have adequate recruitment arrangements in place in accordance with Schedule 3 of the Health and Social Care Act 2008. The required employment checks were not in place for all staff. Key documentation was missing from staff files to demonstrate their fitness to work at the practice.