Dr Touseef Safdar

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Dr Touseef Safdar, Central Clinic, Hall Street, Dudley, on 14 January 2015 as part of a comprehensive inspection. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and well-led services. The areas for improvements that led to these ratings also applied to all of the six population groups that we inspected and which are also rated as requires improvement. These were, people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health. We rated the practice good for providing an effective, caring and responsive service.

Our key findings were as follows:

- The systems in place to ensure patients received a safe service were not robust.
- The practice did not have effective systems to engage and work in collaboration with other services and health care professionals in the management of patients with complex and long term conditions. The system in place for reviewing patients test results and referrals was not clear. The lead GP did not assess mental capacity in accordance with the requirements of the Mental Capacity Act (2005).
- Patients were complimentary about the staff at the practice and said they were caring, listened and gave them sufficient time to discuss their concerns.
- The practice was responsive to the needs of the practice population. There were services aimed at specific patient groups.
- The leadership structure in place was not clearly defined. Staff spoken with were committed to providing a high quality service. However, they described the overall leadership culture as lacking support and direction.

Summary of findings

There were particular areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Operate effective recruitment procedures and ensure that the information required under current legislation is available in respect of all staff employed to work at the practice.
- Improve engagement and collaboration with other services and health care professionals in the management of patients with complex and long term conditions.
- Assess mental capacity in accordance with the requirements of the Mental Capacity Act (2005).
- Have a clear procedure in place for reviewing patients test results and referrals to ensure they are reviewed in a timely manner.
- Improve the governance arrangements at the practice by assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others. Ensure sensitive patient information is maintained securely and available only to relevant professionals. Seek and act on feedback from staff, for the purposes of continually evaluating and improving the service.

In addition the provider should:

- Ensure there are systems in place to ensure important information is shared with all staff such as patient safety alerts and the business continuity plan.
- Have clear processes in place for staff to follow so that patients with no fixed address or those requiring temporary registration can be seen or be registered at the practice.
- Proactively identify and support those with caring responsibilities.
- Ensure processes are in place to assure themselves that regular cleaning of the general environment and equipment used for patients care and treatment has been undertaken to an appropriate standard.
- Ensure records are in place to evidence that clinical staff have relevant vaccinations appropriate to their role in line with the General Medical Council's Good Medical Practice (GMP) guidance.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services There was evidence of regular checks of emergency medicines and equipment. Guidance was available on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately reported and investigated. However, recruitment processes were not sufficiently robust to ensure that the information required under legislation was available in respect of all staff employed to work at the practice. The systems in place to ensure important information was shared with all staff such as significant events, patient safety alerts, complaints was not fully effective. Essential risks such as fire, legionella and risks associated with the premises and patient sensitive information had not been assessed and managed.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services Clinical audits were completed to ensure patients' care and treatment was effective. There were examples of evidence based practice which was referenced in patients care and treatment to help ensure positive outcomes were achieved. There were arrangements in place to identify, review and monitor patients with some long term conditions and those in high risk groups to ensure patients received the care and support that they needed. However, the practice did not have effective systems to engage and work in collaboration with other services and health care professionals in the management of patients with complex and long term conditions. The system in place for reviewing patients test results and referrals was not clear. The lead GP did not assess mental capacity in accordance with the requirements of the Mental Capacity Act (2005).

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said that staff were caring and understanding and their privacy and dignity was respected. Patients told us that staff listened and gave them sufficient time to discuss their concerns and they were involved in making decisions about their care and treatment. Data from the national GP survey 2013-2014 showed that patients rated the practice average for several aspects of care such as being treated with care and concern by a GP and nurse and patients overall experience of their GP practice.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. The practice had arrangements in place to respond to the needs of specific patient groups. Patients with no fixed address or those requiring temporary registration could be seen or be registered at the practice, although not all staff were aware of the process in place. There were vaccination clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated. The practice was responsive to complaints with evidence demonstrating that they acted on issues raised in a proactive manner.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for being well-led. The practice had a vision and was working towards delivering this although this had not been formally documented. The practice had a number of policies and procedures to govern activity however, some of the polices had not been reviewed and lacked sufficient detail. There was some evidence of improvements made as a result of audits and feedback from patients. However, the governance arrangements at the practice were not robust and the leadership structure was not supportive, lacked direction and staff engagement. Essential risks such as fire, legionella and risks associated with the premises and sensitive patient information had not been assessed and managed.

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

Requires improvement

The provider was rated as requires improvement for providing a safe, effective and well-led service. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of older people.

The practice had a lower than the national average practice population aged 65 years and over. Patients over 75 years of age had named GP. This is an accountable GP to ensure patients over the age of 75 years receive co-ordinated care. There were arrangements to review patients in their own home if they were unable to attend the practice. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. However, the practice was below average for dementia diagnosis rate adjusted by the number of patients in residential care homes.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for providing a safe, effective and well-led service. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for people with long-term conditions.

Patients with long term conditions such as diabetes and asthma were reviewed by the GPs and the nurse to assess and monitor their health condition so that any changes to their treatment could be made. The practice identified and recalled patients with long term conditions during normal surgery time, the GP told us that this allowed patients more flexibility. Health checks and medication reviews took place in conjunction with the Clinical Commissioning Group (CCG) pharmacist. These arrangements helped to minimise unnecessary admissions to hospital.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for providing a safe,effective and well-led service. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of families, children and young people.

Summary of findings

Antenatal care was provided by the midwife who undertook clinics at the practice. Post natal checks were completed by GPs to ensure a holistic assessment of women's physical and mental wellbeing following child birth. Women were offered cervical screening and there were systems in place to audit the results.

Children under the age of 5 years had access to the Healthy Child Programme. The practice had an allocated health visiting team who undertook clinics at the health centre. This enabled good working relationships and systems in place for information sharing. Safeguarding procedures were in place for identifying and responding to concerns about children who were at risk of harm. However, the practice did not ensure risks, such as stairs that were easily accessible, to children were assessed and managed.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for providing a safe,effective and well-led service. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of working age people (including those recently retired and students).

The practice had extended opening hours early mornings, late evenings and during the weekends. Telephone consultations were available so patients could call and speak with a GP or a nurse where appropriate if they did not wish to or were unable to attend the practice. At the time of our inspection patients were not able to book appointments or order repeat prescriptions on line which would benefit working age patients. However, the practice was due to start offering this service from April 2015.

Opportunistic health checks and advice were offered such as blood pressure checks and advice on stopping smoking and weight management. NHS health checks were available for people aged between 40 years and 74 years.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for providing a safe,effective and well-led service. The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for

Summary of findings

the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical services contract (GMS). Annual health checks were undertaken for patients with a learning disability.

There were arrangements in place to enable patients with no fixed address or those requiring temporary registration to be seen or to be registered at the practice. The lead GP described a good process and was knowledgeable about the needs of people whose circumstances may make them vulnerable. However, we found that not all staff were clear of the process in place for patients with no fixed address or those requiring temporary registration to be seen or to be registered at the practice which could be a barrier for patients accessing the service.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for providing a safe,effective and well-led service .The areas for improvement which led to these ratings apply to everyone using the practice, including this population group. Therefore the practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

Patients experiencing poor mental health were offered an annual review of their physical and mental health needs, including a review of their medicines.

Staff worked with local community mental health teams to ensure patients with mental health needs were reviewed, and that appropriate risk assessments and care plans were in place. There was a practice based counsellor and mental health worker who undertook regular clinics to review and support patients.

Summary of findings

What people who use the service say

We looked at the results of the most recent national GP patient survey 2013-2014. Findings of the survey were based on comparison to other practices nationally. The results showed that overall the practice performance in most areas relating to access was average. This included practice opening times, phone access and the proportion who stated that they always or almost always see or speak to the GP they prefer.

As part of the inspection we sent the practice comment cards so that patients had the opportunity to give us feedback. We received 19 completed cards. The feedback we received was positive overall. On the day of the inspection we spoke with six patients including one member of the patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. Patients described staff as caring and helpful and said their privacy and dignity was respected. However, some patients told us that they were not always able to see their preferred GP.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were 14 comments posted on the website in the last year, and of these the majority were negative comments relating to staff attitude and behaviour. The practice had not replied to any of the comments to demonstrate that they were engaging and listening to patient feedback to improve the quality of the service.

Areas for improvement

Action the service MUST take to improve

- Operate effective recruitment procedures and ensure that the information required under current legislation is available in respect of all staff employed to work at the practice.
- Improve engagement and collaboration with other services and health care professionals in the management of patients with complex and long term conditions.
- Assess mental capacity in accordance with the requirements of the Mental Capacity Act (2005).
- Have a clear procedure in place for reviewing patients test results and referrals to ensure they are reviewed in a timely manner.
- Improve the governance arrangements at the practice by assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others. Ensure sensitive patient information is maintained securely and available only to relevant professionals. Seek and act on feedback from staff, for the purposes of continually evaluating and improving the service.Have a clear procedure in place for reviewing patients test results and referrals to ensure they are reviewed in a timely manner.

Action the service SHOULD take to improve

- Ensure there are systems in place to ensure important information is shared with all staff such as patient safety alerts and the business continuity plan.
- Have clear processes in place for staff to follow so that patients with no fixed address or those requiring temporary registration can be seen or be registered at the practice.
- Proactively identify and support those with caring responsibilities.
- Ensure processes are in place to assure themselves that regular cleaning of the general environment and equipment used for patients care and treatment has been undertaken to an appropriate standard.
- Ensure records are in place to evidence that clinical staff have relevant vaccinations appropriate to their role in line with the General Medical Council's Good Medical Practice (GMP) guidance.

Dr Touseef Safdar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and included a specialist advisor GP and a specialist advisor practice manager with experience of primary care services.

Background to Dr Touseef Safdar

Dr Touseef Safdar is a single handed GP practice based in a purpose built health centre owned and maintained by NHS property services and shared with other health care services. The registered patient list size is approximately 4400 patients.

The practice has a Personal Medical Services (PMS) contract with NHS England. A PMS contract is agreed locally and is an alternative to a General Medical Services (GMS) contract for providers of general practice but still provides essential services for people who are sick as well as for example, chronic disease management and end of life care.

Dr Touseef Safdar is open Mondays to Fridays 7am and 8pm. The practice also opens Saturdays and Sundays between 8am and 1pm as part of a local enhanced service (LES) however, this was expected to continue only until April 2015. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by 'Prime care' the external out of hours service.

The staffing establishment at Dr Touseef Safdar includes clinical staff compromising of one GP who was also the registered provider (male), one salaried GP (female) a long term locum GP (female) and a practice nurse (female). There are five administrative staff, two apprentices and a practice manager.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in one of most deprived areas in Dudley. Data showed that the practice has a below average practice population aged 65 years and over and a higher than average percentage of patients under the age of 18 years in comparison to other practices across England. The practice achieved 95.9 points for the Quality and Outcomes Framework (QOF) for the last financial year 2012-2013. This was slightly below the national average of 96.4. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

This provider has been inspected before using our previous methodology, the provider was last inspected on 4 September 2014 and the provider was not meeting Regulation10 (Assessing and monitoring the quality of service provision). This comprehensive inspection included a follow up of the outstanding actions from the previous inspection.

Why we carried out this inspection

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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice. We also asked other organisations to share what they knew. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received19 completed comment cards where patients shared their views and experiences of the service. We carried out an announced visit on 14 January 2015. During our inspection we spoke with a range of staff including the practice manager, clinical and non clinical staff. We spoke with patients who used the service and observed the way the service was delivered.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had some arrangements in place to identify risks and improve patient safety. For example, there were policies in place for reported incidents and complaints received from patients and these were discussed in staff meetings. However, some of the staff we spoke with were not clear of the process for recording incidents. We did not see evidence that a system was in place to record incidents so that they could be analysed and managed consistently over time. Minutes of meetings where incidents and complaints were discussed were not routinely distributed to all of the staff to ensure those not in attendance were aware of the incidents and any relevant learning.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice. We saw that three significant events had occurred in the last 12 months, of these two related to prescriptions. As a result of these prescription related incidents a system was developed to minimise the risk of future reoccurrence. However, staff told us that the system was not consistently implemented to ensure effectiveness. There was evidence that significant events were discussed and shared with staff in meetings. However, minutes of meetings where significant events were discussed were not routinely distributed to all of the staff to ensure those not in attendance were aware of the incidents and any relevant learning.

National patient safety alerts were reviewed and actioned by the lead GP however, there was no documented evidence to demonstrate that this information was routinely shared with clinical staff. Patient safety alerts were issued when potentially harmful situations were identified and needed to be acted on.

Reliable safety systems and processes including safeguarding

The practice had safeguarding policies and procedures, and contact numbers for local safeguarding teams for staff to refer to should they have any concerns. There was a lead GP for safeguarding and an alert system was in place to highlight vulnerable adults and children.

We saw evidence that staff including administrative staff had completed safeguarding vulnerable adults and children training. The clinical staff had received safeguarding childrens training appropriate for their role.

Some of the non clinical staff who we spoke with told us that they acted as chaperones and had completed training in this area. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. There was a poster informing patients that a chaperone service was available, which was visible on the waiting room noticeboard.

We saw that details of key codes to gain access to a patient's house when undertaking a home visits were recorded in the patient's electronic records and could be accessible to other health care professionals as part of 'Summary care records'. However, this type of sensitive patient information must be restricted to ensure information was available only to relevant professionals.

Medicines management

Vaccines were stored in two dedicated secure fridges. There were systems in place to ensure that regular checks of the fridge temperatures were undertaken and recorded. This provided assurance that the vaccines were stored within the recommended temperature ranges and were safe and effective to use.

The practice did not store any controlled drugs although a protocol was in place for prescribing controlled drugs to ensure these were handled safely. The practice routinely used electronic prescribing. We saw that paper prescriptions were stored securely and there was a system in place for recording the serial number of paper prescriptions so that all prescriptions could be accounted for and traced in the event this was necessary.

There were arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure medications remained relevant to their health needs.

A pharmacist from the local Clinical Commissioning Group (CCG) worked with the practice which enabled medicine management systems such as repeat prescribing to be monitored and reviewed. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. We spoke with the pharmacist who

told us that there were no prescribing issues at the practice. The most recent data available to us showed that the practice prescribing rates for a number of medicines were in line with the national average.

Cleanliness and infection control

On the day of our inspection we observed that the practice was visibly clean and tidy. There were systems in place to reduce the risk of cross infection. This included the availability of personal protective equipment (PPE) and posters promoting good hand hygiene. There was an infection control policy which had been recently reviewed and a named lead for infection control with responsibility for overseeing good infection control procedures. An infection prevention and control audit had been completed by the practice in December 2014 which covered a range of areas such as hand hygiene, waste disposal and the general environment. We saw evidence that a number of staff had received training in infection prevention and control so that they were up to date with good practice. We found that suitable arrangements were in place for the storage and the disposal of clinical waste and sharps. Sharps boxes were dated and signed to help staff monitor how long they had been in place. A contract was in place to ensure the safe disposable of clinical waste. However, We were unable to see records of cleaning schedules for the environment and equipment used by staff that provided assurance that regular cleaning had been undertaken to an appropriate standard. Some areas of the carpet in the patient waiting area were stained and we saw that the staff toilets were located off the staff kitchen area which did not promote good hygiene. There were visible signs of dampness in the staff toilets with paint peeling off the wall. The lead GP told us they were restricted in what they could do as the property was not owned by them and there were plans to move the practice to another area within the health centre, although this was not confirmed and there were no timescales in place.

There was no record of clinical staff having had relevant vaccinations appropriate to their role. This is not in line with the General Medical Council's Good Medical Practice (GMP) guidance. The lead GP told us that they would forward this information following the inspection however, we did not receive this information.

There were no records of a Legionella risk assessment. Legionella is a term for particular bacteria which can contaminate water systems in buildings. The practice manager and lead GP told us that these records were stored with NHS property services and suggested that we contact them directly as they were unable to send them to us. There was no policy in place and the practice was unable to demonstrate that any potential risks had been assessed and managed.

Equipment

Records showed that medical equipment had been calibrated and serviced so that they were safe and effective to use. Electrical appliances had been tested to ensure they were in good working order and safe to use.

Fire alarms, equipment and emergency lighting were checked by NHS property services to ensure they were in good working order. However, records of checks undertaken were not available at the practice. The practice manager and lead GP told us that these records were stored with NHS property services and suggested that we contact them directly as they were unable to send them to us.

Staffing and recruitment

The registered patient list size was approximately 4400 patients. The practice was a single handed GP practice and the lead GP (male) was also the registered provider. The practice employed one salaried GP (female), a long term locum GP (female) and a practice nurse (female). There were five administrative staff, two apprentice administrators and a practice manager. At our last inspection in September 2014 we were told that a member of administration staff had reduced their working hours and these hours had not been replaced leaving the practice short staffed during busy periods. During this inspection we saw that a further two administrative staff had been employed in November 2014 which had improved the staffing levels. At the time of our inspection a long term locum GP was leaving their post and the practice had started the recruitment process for appointing a replacement locum GP.

There were some systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. Administrative staff were able to cover each other's annual leave and we saw that there were sufficient staff on duty.

We looked at clinical staffing levels. The lead GP explained the difficulties they experienced in the recruitment of GPs. We looked at the system in place for covering clinical staff

absence and we were told by the lead GP that when the nurse was on leave essential work such as vaccinations would be covered by the GPs. The lead GP and salaried GP provided cover for each other and were supported by locum GPs.

We looked at four staff files which included the files of clinical and non clinical and two of the most recent members of staff employed at the practice. There was evidence that some of the appropriate pre-employment checks were completed as part of the recruitment procedure. This included photographic proof of identity, details of professional registration and a Disclosure and Barring Service (DBS) check. The DBS check is a criminal records check that helps identify people who are unsuitable to work with children and vulnerable adults. However, we saw that there was missing information which the manager and the lead GP were unable to locate. For a clinical member of staff there was no medical health information or a DBS check. We also identified during our discussions with non clinical staff that they sometimes acted as chaperones. However, we saw that they did not have a DBS check and the risk assessment in place did not consider if the staff member could be left unattended with the patient. The practice's risk assessment also stated that non clinical staff acting as chaperones would have a DBS check. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

Monitoring safety and responding to risk

There were arrangements to deal with foreseeable medical emergencies. Staff had received training in responding to a medical emergency. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the event of a medical emergency. The practice had oxygen and automated external defibrillator (AED). This is a piece of life saving equipment that can be used in the event of a medical emergency. All of the staff that we asked knew the location of the emergency medicines and equipment. However, we saw that there was only one GP home visit bag which contained emergency medicines and equipment. The lead GP told us that only one GP would be undertaking home visits at any one time.

There were no records of fire drills that had taken place and the fire policy in place lacked sufficient details for example there was no reference to fire drills or meeting point in the event of fire. There was evidence that staff had received fire training and staff told us that they were aware of what to do.

Arrangements to deal with emergencies and major incidents

The practice had an up to date business continuity plan in place. The plan contained areas of potential risks relating to foreseeable emergencies that could impact on the delivery of the service. The business continuity plan was only accessible to the lead GP and the practice manager and was not shared with staff so that they were prepared in the event of an emergency or major incident.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found from our discussions with the lead GP and nurse that they were familiar with current best practice guidance, and could access guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. There were examples of the practice implementing best practice in line with NICE guidelines for example, changes to prescribed medicines to ensure most effective outcomes for patients.

The practice did not have specific clinics to review patients with long term conditions such as diabetes, asthma, hypertension and heart disease as they found these were not effective. The practice identified and recalled patients during normal surgery time; the GP told us that this allowed patients more flexibility. National data showed that the practice was in line with other practices for referral rates to secondary services such as for cancer referrals.

We saw that there were 47 patients registered at the practice with a mental health need. A system was in place to ensure these patients could be easily identified and were offered a review. We saw evidence that care plans were in place for the majority of patients. Data that we reviewed showed that the practice was comparable to other practices nationally for indicators relating to mental health.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included prescribing. The practice showed us two clinical audits that had been undertaken in the last year, both were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, after one audit, some patients were prescribed an alternative more effective medicine for their health condition based on NICE guidance. However, there was no evidence of clinical meetings that demonstrated information was shared with clinical staff.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients with diabetes, on the register, with a record of a foot examination. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The practice had met a number of the minimum standards for QOF in areas such as diabetes and mental health. However, the practice was below national averages for three QOF targets. The percentage of women aged 25 or over whose notes record that a cervical screening test had been performed in the preceding 5 years was 0.628, this was below the national average of 0.819. However, the GP showed us local data which demonstrated that the practice was average in comparison to other local practices. The practice was also below the national average for dementia diagnosis rate adjusted by the number of patients in residential care homes and the ratio of expected to reported prevalence of Coronary Heart Disease (CHD). The lead GP told us that some patients with dementia had been incorrectly coded on to the clinical system and the practice was working to identify these patients however, no further evidence was provided. The lead GP was unable to provide a clear explanation for why the ratio of expected to reported prevalence of CHD was below national average.

Childhood vaccinations were provided during normal surgery time. National data that we reviewed showed that the practice was below average in a number of childhood vaccinations. For example, only 94.7% of eligible children at the practice had received the Meningitis C vaccination, which was below the average rate of 98.9% receiving vaccinations in the Clinical Commissioning Group (CCG). We discussed this with the practice nurse who performed childhood vaccinations. They told us that there were no specific clinics for undertaking vaccinations and that children were invited during normal surgery hours to allow parents more flexibility and open access. There were systems in place to identify and follow up children who did not attend and this included discussions with the health visitor. We spoke with the health visitor who told us that no formal meetings took place however, arrangements were in place to discuss any concerns.

Requires improvement

Are services effective?

(for example, treatment is effective)

Effective staffing

There was no training log for the GPs to provide assurance that they were up to date with their training. However, we saw training certificates in two of the GPs' files; these were for safeguarding children and adults and responding to a medical emergency. The practice nurse had completed training relevant to their role for example immunisation updates and smoking cessation. Training for non clinical staff was recorded on a training log and showed training completed such as responding to a medical emergency, infection control and safeguarding children and adults. However, staff we spoke with on the day of the inspection gave mixed views on training and development opportunities with some staff feeling that there was a lack of support for training.

There was evidence of annual appraisals for all staff including the GPs and we saw evidence of completed appraisals.

The lead GP at the practice had undergone external revalidation of their practice. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The lead GP told us that they were responsible for reviewing all of these and acting on them as required and in their absence another GP at the practice undertook this role. However, this conflicted with what other staff reported. Staff told us that unless marked urgent any results of tests and investigations would not be reviewed until the lead GP returned. We were unable to speak with any of the other GPs on the day of our inspection as they were not on duty.

The lead GP told us that no meetings were held with health care professionals such as the district nurses and Macmillan nurses in line with the Gold Standard Framework (GSF) for end of life care. This was because, at the time of our inspection the practice only had one patient receiving end of life care. However, informal arrangements were in place to share information. The GSF helps doctors, nurses and care assistants provide the highest possible standard of care for all patients who may be in the last years of life.

As part of our inspection we spoke with various health care professional to discuss how the practice worked with other service providers to meet patients' needs and manage complex cases. There were examples of the practice working with other services and professionals such as the community mental health nurse and the CCG pharmacist. However, some of the feedback we received suggested that the practice did not always communicate effectively to enable a better working relationship and a collaborative approach to managing patients' health needs.

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. The practice referred patients to secondary and other community care services such as district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the legislation and were able to describe how they implemented it in their practice. The practice had a consent policy to provide guidance for staff.

Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. However, the lead GP told us that they did

Requires improvement

Are services effective?

(for example, treatment is effective)

not assess mental capacity in accordance with the requirements of the Mental Capacity Act (2005) as they said they would refer any concerns about capacity to secondary services.

All clinical staff demonstrated an understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice had no policy in place to ensure the needs of these patients were addressed appropriately.

Information leaflets and posters were available in the patient waiting area relating to health promotion and prevention. A television in the patient waiting area that could be useful in disseminating health promotion and prevention advice was out of order and there was no clear plan of when it would be repaired.

The practice offered advice and support in areas such as smoking cessation and there were arrangements in place for NHS health checks for people aged between 40 years and 74 years. The practice offered a full range of vaccinations for children and flu vaccinations in line with current national guidance.

The practice had a carers' register with five carers identified. We saw that the practice's computer system did not alert staff if a patient was a carer. The GP told us that as it was a small practice, staff knew their patients well and could identify those people who were carers and offer them support as necessary. However, the system relied on carers identifying themselves to the practice. The practice was not proactive in promoting the support available. For example, there was a carers' information leaflet but this was stored behind the reception desk and not on display in the patient waiting area. This could result in carers not being aware of the services available to them.

Cervical screening (smear test) was undertaken by the practice nurse with a national recall system in which patients were invited to attend the practice.

The practice provided antenatal and post natal care for women, there was a midwife based in the practice who undertook regular clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 19 completed cards and the majority were positive about the service experienced. Patients said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey 2013-2014. The results of the national GP survey highlighted the practice was average in most areas in comparison to other practices nationally. For example, data showed the practice was rated average for the proportion of respondents who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern.

The layout of the patient waiting area meant that patient confidentiality was not always maintained. Patients at the reception desk could be overheard when talking to staff. Staff taking incoming calls could also be heard. Feedback from the national GP survey identified this as an area for improvement. We did not see any information displayed informing patients that they could discuss any issues in private away from the main reception desk. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room and that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations.

A poster was on displayed in the patient waiting area informing patients that a chaperone service was available. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

There were both male and female GPs working at the practice. This gave patients the option of receiving gender specific care and treatment.

Care planning and involvement in decisions about care and treatment

The lead GP told us that they did not assess mental capacity in accordance with the requirements of the Mental Capacity Act (2005) as they said they would refer any concerns about capacity to secondary services. Data from the national GP patient survey showed the practice was rated average in areas relating to involvement in decisions about patients care when compared to practices nationally.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

We did not see any information in the patient waiting room on how to access support groups and organisation for patients who were carers or required emotional support following bereavement. There was no written information available to ensure these vulnerable groups understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered core services to meet the needs of the main patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as diabetes. There were vaccination clinics for babies and children and women were offered cervical screening. Patients over the age of 75 years had a named GP to ensure their care was co-ordinated.

At our last inspection in September 2014, the practice had set up a patient participation group (PPG) which had met once. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. During this inspection we saw that a further meeting had taken place in November 2014. At the time of our inspection the PPG had six members, we spoke with one of the members, they told us there had been some difficulties in the group meeting more frequently and acknowledged that they were still developing as a group although they were actively trying to engage with patients to get their feedback, There were examples of actions taken as a result of feedback from patients such as the issue of poor lighting in the car park and seeking further feedback from patients in response to the national GP survey.

Tackling inequity and promoting equality

We did not see any notices in the reception areas informing patents that a translation service was available. However, staff told us that translation services were available for patients who did not have English as a first language.

There were baby changing facilities at the practice which would be helpful for parents with babies and young children. We saw that there were steps in the patient waiting area which were easily accessible to children. There was no child safety system in place although there was a poster informing parents not to allow children to play on the stairs.

The premises was owned by NHS property services, this limited the changes that could be made to the building. The premises was also shared by other services. We saw that there were some arrangements for patients with a physical disability to access the service. There were accessible toilet facilities, allocated parking bays and automatic doors at the main entrance into the building.

However, patients would have to negotiate steps to access parts of the building and there were no risk assessments in place. Access to the building via the practice entrance would be difficult for someone with mobility difficulties as the practice was on a steep hill. The practice had completed a checklist to assess compliance with the Equality Act (2010). This Act ensures providers of services do not treat disabled people less favourably, and must make reasonable adjustments so that there are no physical barriers to prevent disabled people using their service. However, this was not sufficiently detailed to enable the practice to best assess access for patients with a disability.

Equality and diversity training was undertaken through e-learning to ensure staff were aware of the importance of ensuring the principles were implemented in practice.

There were arrangements in place to enable patients with no fixed address or those requiring temporary registration to be seen or to be registered at the practice. The lead GP described a good process and was knowledgeable about the needs of people whose circumstances may make them vulnerable. However, the practice did not have a policy in place and we found that not all staff were clear of the process in place for patients with no fixed address or those requiring temporary registration to be seen or to be registered at the practice which could be a barrier for patients accessing the service.

Access to the service

The practice was open Mondays to Fridays 7am and 8pm. The practice was also open Saturdays and Sundays between 8am and 1pm. The practice had opted out of providing out-of-hours services to their own patients. This service was provided by 'Prime care' the external out of hours service.

At our last inspection in September 2014, some staff members we spoke with felt there were insufficient numbers of staff dedicated to answering telephone lines. The practice manager also told us that they often heard patents verbally complain about the lack of access to appointments but there were no formal processes to capture this information. No audits had been carried out to assess demand for appointments, the number of telephone calls received each day or the number of patients that had not attended their appointment (DNA). During this inspection there was evidence of some

Good

Are services responsive to people's needs?

(for example, to feedback?)

improvements made. We saw that a further two administrative staff had been recruited and there was sufficient staff to cover the reception area with no evidence of patients waiting an excessive amount of time.

An audit had been completed on access to appointments looking at capacity and demand. The telephone system had been adjusted to ensure there were more telephone lines for incoming calls. We saw that the practice offered extended hours which included weekends. Minutes from a Patient Participation Group (PPG) meeting showed that patient feedback was being sought in areas such as access to appointments. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. There was evidence that the practice had low numbers of patients not attending for appointments (DNA) and therefore these were not routinely followed up. However, the manager told us that if it became an issue, a follow up of frequent DNAs would be initiated such as a letter or a telephone call. We looked at the results of the most recent national GP patient survey 2013-2014. Findings of the survey were based in comparison to the average for other practices nationally. The results showed that overall the practice performance in most areas relating to access was average. This included opening times and phone access. Our discussions with patients on the day and feedback from completed comment cards were mostly aligned with these views.

We looked at the appointment system at the practice. We saw that there was timely access with appointments available a month in advance as well as urgent appointments that were released each day. Home visits were undertaken for those patients who were unable to attend the practice. Telephone consultations were available so that patients could speak to a GP or a practice nurse. Patients had the opportunity to book a double appointment if they required additional time. At the time of the inspection practice did not offer online booking for appointments or ordering of repeat prescription to allow patients for example, those of working age more flexibility. However, the practice was due to start offering this service from April 2015. Data from the national GP survey showed that the practice was average for the proportion of patients who stated that they always or almost always see or speak to the GP they preferred. However, feedback from some patients on the day of the inspection highlighted that they were not always able to see their preferred GP with some commenting the availability of the lead GP was limited. We saw on the electronic appointment system that the lead GPs appointment slots between mid-mornings to mid-afternoon were sometimes blocked. The GP explained that this was to allow them time to catch up on their paperwork and cover extended hours opening. However, this meant that the other GPs were seeing on average 35 patients a day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We saw that there had been four complaints in the last year and there was evidence that these had been responded to with lessons learnt shared with staff in team meetings.

We saw that the complaints poster was on display in the patient waiting area and informed patients to contact the practice manager with any complaints or concerns, but it did not include contact details of organisations that patients could escalate complaints to. The complaints form was also only available from reception staff which may discourage patients from requesting a form. We discussed this with the practice manager who agreed to include this information on the poster to ensure it was accessible to patients.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The lead GP told us of plans to develop and expand service provision for the future, although these plans had not been formally documented. This included establishing the practice as a training practice for GP registrars and transferring the practice to another area within the health centre to improve the facilities for patients. There was some evidence that the practice vision had been shared with staff. For example, we looked at minutes of the practice meeting held in December 2014 and saw that plans regarding the premises had been discussed with staff.

The lead GP told us that the practice was innovative in offering a flexible service by opening seven days a week. This was part of a local enhanced service (LES) and was expected to continue only until April 2015.

Governance arrangements

The practice had policies and procedures in place to govern activity and these were available to staff in a paper format. We looked at a number of these policies and saw that some had been reviewed and were up to date. However, we saw examples of polices that were not detailed or dated. The fire policy made no reference to fire drills or meeting points in the event of a fire. The chaperone policy did not state where staff should stand to be able to observe the examination. The practice had a whistleblowing policy but it was not comprehensive. Whistleblowing is when staff are able to report suspected wrong doing at work confidentially, this is officially referred to as 'making a disclosure in the public interest'. The complaints and consent policy were not dated so it was not clear when they had been reviewed. There was no system in place to confirm staff had read the relevant policies.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The practice achieved 95.9 points for the QOF for the last financial year 2012-2013. This was slightly below the national average score of 96.4. There was no evidence that QOF data was regularly discussed at monthly team meetings and action plans produced to improve outcomes. The practice did not hold any governance or clinical meetings so that performance, quality and risks could be discussed.

The lead GP told us about the CCG 'Score Card' system used to monitor the quality and performance of the practice. This included 15 GP practices in the locality and enabled the practice to measure its performance against others and identify areas for improvement. We saw evidence that the practice had comparable scores in a range of areas identified by the CCG to practices locally including the number of accident and emergency attendees. The lead GP also told us that they attended meetings with the CCG. However, our discussions with staff indicated that they did not attend CCG led events such as forums and protected learning time.

At our last inspection in September 2014, the practice did not have an effective system to regularly assess and monitor the quality of service that people received. During this inspection there was evidence of some improvements made such as clinical audits to improve patient outcomes. The practice had also completed an infection control audit and an audit on capacity and demand looking at access to appointments.

The practice had some arrangements for identifying, recording and managing risks. The practice manager showed us a risk assessment, which addressed potential issues, for example aggressive patients. However, the risk assessment did not cover a wide range of areas and there was no evidence that it was regularly discussed at team meetings and updated in a timely way. Risk assessments had not been carried out where risks were identified and action plans had not been produced and implemented. For example, the general environment was not child friendly and access for patients with a physical disability had not been audited. There was no evidence that patient safety alerts and risks included in the business continuity plan were shared with staff who were unable to attend staff meetings. The lead GP told us that they did not assess mental capacity and would refer any concerns about capacity to secondary services.

Leadership, openness and transparency

Staff spoken with were committed to providing a high quality service. However, they described the culture of the

Are services well-led?

Requires improvement

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

organisation as lacking openness and transparency. Staff told us they felt well supported by the practice manager but felt the overall leadership structure lacked support, direction and staff engagement.

The practice had a whistleblowing policy although, our discussions with some staff told us that they did not feel confident to raise any concerns. Whistleblowing is when staff are able to report suspected wrong doing at work confidentially, this is officially referred to as 'making a disclosure in the public interest'.

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

The practice gathered feedback from the staff generally through appraisals, meetings and informal discussions. However, staff who we spoke with told us that they did not always feel listened to.

We saw that staff meetings took place and there was opportunity for staff feedback although these minutes were not circulated to ensure staff not in attendance were aware of important information discussed. Our discussions with staff indicated that they felt de motivated and their knowledge and skills were not always being utilised effectively. Staff also told us that decisions were sometimes made with little staff engagement. This was an area identified for improvement at our last inspection in September 2014. We discussed this with the lead GP who gave us a different perspective suggesting that staff were able to add any issues to the staff meeting and there was an open door policy. We saw evidence that staff feedback was included on the staff meeting minutes. However, staff members perspective on the management of the practice contradicted that of the lead GP suggesting a lack of insight on the issues affecting staff.

There was evidence that the practice was working alongside the Patient Participation Group (PPG) to act on patient feedback which had resulted in changes being made although the PPG was still developing as a group. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The practice manager and the lead GP attended PPG meetings to ensure they remained fully involved and aware of feedback from patients.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. There were 14 comments posted on the website in the last year, of these the majority were negative comments relating to staff attitude and behaviour. The practice had not replied any of the comments to demonstrate that they were engaging and listening to patient feedback to improve the quality of the service.

Management lead through learning and improvement

We looked at a sample of staff files and saw that appraisals took place which included a personal development plan. However, staff we spoke with on the day of the inspection gave mixed views on training and development opportunities. Some of the staff told us that the practice was not always supportive of training and that training requests were not always acted on.

The leadership structure was not clearly defined and some of the staff members we spoke with were not clear about their roles and responsibilities. They told us that they did not feel valued, and there was a lack of supportive leadership.

Learning from complaints, significant events and incidents were shared with staff in meetings to help learning and improvements. The minutes of meetings were not routinely circulated to ensure all staff were aware of the issues discussed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not operate an effective recruitment procedure. Appropriate checks were not always completed prior to staff commencing their post. Clinical staff did not have a Disclosure and Barring Service (DBS) check or evidence of medical health information. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (1) (c) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have effective systems to engage and work in collaboration with other services and health care professionals in the management of patients with complex and long term conditions This was in breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

We found that the registered person did not assess mental capacity in accordance with the Mental Capacity Act (2005).

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person did not have effective systems in place to assess, monitor and manage risks. There was a lack supportive leadership and systems to engage and motivate staff. Policies and procedures were not reviewed to ensure they were detailed and up to date. Essential risks had not been assessed and managed. These included fire, legionella, risks associated with the premises, sensitive patient information, and the reviewing of patients test results and referrals. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1) (2) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014