Dr Muhammad Misbah-Ur-Rehman Siddiqui

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 9.00 am on 21 April 2015. The practice had previously been inspected during our pilot phase in August 2014. We must conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

Overall the practice is rated as good.

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

Our key findings were as follows:

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

There was clear leadership in place with named members of staff in lead roles.

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

The provider should:

Provide training for non-clinical staff in safeguarding children and vulnerable adults.

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Provide annual update training for all staff in basic life support in line with the UK resuscitation council guidelines.

Ensure a legionella risk assessment is in place to identify and mitigate risk associated with legionella bacteria.

Ensure clinical audit cycles are completed to demonstrate improvements in patient outcomes.

Carry out annual, written appraisals for non-clinical staff.

Develop a vision for the practice which involves the improvement of the quality of patient care and share with staff.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams. Staff had received training appropriate to their roles, however some mandatory training and appraisals were absent for non-clinical staff and clinical audit cycles were not completed to demonstrate improved outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Although data showed that patients rated the practice lower than others for several aspects of care. Patient's feedback on the day of our inspection showed that they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said that sometimes it was difficult to get a routine appointment, however they said that there was good continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

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Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a vision, however it did not address ways of improving the quality of patient care. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and attended staff meetings although some mandatory training and appraisals were lacking for non-clinical staff.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice had a lower than National average number of older patients. The percentage over 75 years was 6.6% and over 85 years was 1.6% (National average 7.6% and 2.2% respectively). Patients over 75 years had a named GP and were prioritised to see the GPs including emergency appointments. Those at risk of unplanned admission to secondary care had care plans in place. End of life care was managed by district nurses who liaised with the practice at multidisciplinary team meetings. The practice offered open access appointments for older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 52.8% and 42.8%. These were lower than the England averages of 54% and 48.8%. The practice had signed up for the Whole System Integrated Care Programme (a programme where health and social care services work together to provide integrated care to patients with long-term conditions). The practice participated in the avoiding unplanned admissions Enhanced Service and used the BIRT 2 tool (Business Intelligence Risk Stratification Tool) to identify patients with long-term conditions who were at risk of hospital admissions. The practice had identified 2% of the practice population who were at risk of hospital admissions which was 72 patients and care plans were in place to manage their care needs. Patients were given copies of their care plans and a questionnaire to feedback their opinions of the service. The practice's Quality and Outcomes Framework (QOF) performance for all long-term conditions was above both the Clinical Commissioning Group (CCG) and National averages in 2013/14.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had a higher number of children aged 0 to 4 years compared to the National average (7% compared to 6%) and the percentage of children aged 5 to 14 years was 11.4% which was in line with the national average. The practice provided a range of services for families, children and young people. These included post-natal checks for mother, six week baby checks, family planning clinics and contraceptive services. The practice did not provide antenatal checks for mothers, however along with patients from

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other practices in the locality patients were referred to an adult and child centre through choose and book. The practice provided the routine childhood immunisations including the new Hepatitis B and Rotavirus vaccinations. Uptake for most childhood immunisations was above the National average in the previous year. The practice offered the Measles, Mumps and Rubella (MMR) vaccinations for young people aged 16 and over. Chlamydia screening was available and patients were referred to a specialist clinic for Sexually Transmitted Diseases (STDs).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The percentage of patients in paid work or full time education was 60% which was in line with the national average of 60.2%. The practice provided the extended opening hours Enhanced Service (ES) for those patients of working age. Nine additional appointment slots per week after 7 pm were available for patients who could not attend the practice during normal working hours. Appointments and repeat prescriptions could be accessed online for those of working age. Telephone consultations were available for minor ailments. NHS Health Checks were available for patients between the ages 40-74 years and Meningitis C vaccinations for students attending university.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice kept a register of patients with learning disabilities and provided annual physical health checks. Patients with no fixed abode such as asylum seekers, substance misusers and travellers who were not registered with a GP practice were seen as temporary patients and were signposted to support groups and services according to their needs. The practice had been adapted to meet the needs of patients who were disabled. For example, there was a ramp at the entrance for wheelchair access, wide doorways to the consultation rooms, and the toilet had an emergency pull cord which was connected to all rooms in the practice. A hearing loop was available for those patients hard of hearing. The practice provided care for a small number of patients in a local nursing home and home visits were available for patients who were unable to travel to the practice. The practice had access to online and telephone translation services for those patients whose first language was not English.

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People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were called in for reviews at the practice and referred to the local mental health team for mental health assessments and management. The practice's QOF performance for mental health and dementia was 100% in 2013/14. All patients in the age group 40-74 who do not have any disease registered were offered a NHS Health Check and asked to complete a dementia questionnaire. Patients with any signs of dementia were referred to secondary care.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection including four members of the Patient Participation Group (PPG). We reviewed 26 CQC comment cards which had been completed by a patient prior to our inspection, data from the 2014 National GP Patient Survey, and feedback from patients from the Friends and Family Test (FFT) and patient questionnaires conducted by the practice. Data from the National Patient Survey showed that patients rated the practice 'amongst the worst' for recommending the practice to someone new in the area. However, patients also rated the practice higher than others for several aspects of care. For example, satisfaction scores on consultations with clinical staff and confidence in the nurse. Feedback from patient questionnaires showed that patients had to wait too long for an appointment however the practice had taken action to address this. The majority of comment cards we received were positive about the service patient's received from their GP practice. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. This aligned with what patients told us on the day of our inspection.

Areas for improvement

Action the service SHOULD take to improve

Provide training for non-clinical staff in safeguarding children and vulnerable adults.

Provide annual update training for all staff in basic life support in line with the UK resuscitation council guidelines.

Ensure a legionella risk assessment is in place to identify and mitigate risk associated with legionella bacteria.

Ensure clinical audit cycles are completed to demonstrate improvements in patient outcomes.

Carry out annual, written appraisals for non-clinical staff.

Develop a vision for the practice which involves the improvement of the quality of patient care.

Dr Muhammad Misbah-Ur-Rehman Siddiqui

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP and a practice manager who were granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Dr Muhammad Misbah-Ur-Rehman Siddiqui

Dr Muhammad Misbah-Ur-Rehman Siddiqui is situated at 21 Walnut Way, Ruislip, Middlesex, HA4 6TA. The practice provides primary medical services through a General Medical Services (GMS) contract to approximately 3340 patients living within the local area. (GMS is one of the three contracting routes that have been made available to enable commissioning of primary medical services). The practice is part of the NHS Hillingdon Clinical Commissioning Group (CCG) which is made up of 48 GP practices. The practice population is culturally diverse with a higher than National average of female patients between 30 and 40 years, male patients 30 to 50 years and children up to four years. Life expectancy is 80 years for males and 84 years for females, which is higher than the National average, and the local area is the fourth least deprived in the Hillingdon CCG (people living in more deprived areas tend to have greater need for health services).

The practice team consists of a full time male GP, long-term locum female GP (one day per week), full time practice manager, a nurse (30 hours) and four reception/ administration staff.

The service provides a wide range of clinics and services including the management of long-term conditions, cervical smears, childhood and travel immunisations, family planning, hormone replacement therapy, smoking cessation, contraception, mother / infant checks, removal of sutures, dressings, well woman / man clinics and nutritional therapy.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedure, and the treatment of disease, disorder and injury.

The practice's opening hours are Monday to Friday 8.00 am to 7.30 pm except Wednesday when the practice closes at 7.00 pm and Thursdays when the surgery closes at lunchtime.

The practice has opted out of providing out-of-hours services to their own patients and directs patients to a local out-of-hours provider. Patients can also access a 24 hour urgent care centre adjacent to the local hospital.

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, and to look at the overall quality of the service. The practice had previously been inspected during our pilot phase in August 2014, and we have an obligation to conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 April 2015. During our visit we spoke with a range of staff including a GP, nurse, practice manager, two reception / administration staff and spoke with eight patients who used the service four of whom were members of the Patient Participation Group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 26 completed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the practice had noted an increased incidence of cancer diagnosis which had been reported as a significant event. The practice took action to remind staff of the importance of prompt diagnosis and referral.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked nine incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, one incident recorded involved an aggressive and abusive patient. The patient was dealt with in line with the practice's zero tolerance policy. We saw evidence through meeting minutes that learning was shared with all the relevant staff.

National patient safety alerts were disseminated by the lead GP to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for example medicine alerts from the clinical commissioning group (CCG) medicines management team. They also told us alerts were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example, we saw evidence from meeting minutes that the lead GP had shared an update on the Ebola virus with staff and informed them of the procedures for managing suspected Ebola cases.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that clinical staff had training in child protection to Level 3 and they had also received training in safeguarding adults. However, we found no evidence of child protection training for three out of four non-clinical staff and for one the training had not been updated since 2010. We also found no evidence of safeguarding adults training for non-clinical staff. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had an appointed dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy and a poster which was visible on the consulting room doors. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting

as chaperones, including where to stand to be able to observe the examination. The practice had undertaken criminal records checks via the Disclosure and Barring Service (DBS) on all staff acting as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice did not have a written policy for ensuring that medicines were kept at the required temperatures, however staff could outline the procedures for the safe storage of medicines and could describe the action to take in the event of a potential failure. We found that all vaccines were stored within the correct temperature range.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice did not hold stocks of controlled drugs.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw examples of Patient Group Directives (PGDs), for example those for the administration of the measles, mumps and rubella (MMR) vaccines and shingles vaccines. (PGDs are written instructions from a GP for non-prescribing health care professionals to legally administer medicines). We saw evidence that the nurse had received appropriate training to administer vaccines. The practice nurse had also recently qualified as an independent prescriber although she was not carry out this role at the time of our inspection.

All prescriptions were reviewed and authorised by the GPs electronically before they were given to the patient. Blank prescription forms were kept for emergencies or home visits and were handled in accordance with national guidance as these were tracked through the practice and kept securely in a locked safe in the lead GPs room at all times.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and thereafter biannual updates. We saw evidence that the lead nurse for the clinical commissioning group (CCG) had carried out an audit in 2014 and that any improvements identified for action were completed on time. For example, the audit identified cracked and peeled paint work in the clinical areas and this had been repaired.

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

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

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) and no risk assessment had been completed to identify and mitigate risks.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in the previous twelve months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, fridge thermometer, ear syringes and electrocardiogram (ECG) machines.

Good

Are services safe?

Staffing and recruitment

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

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

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. However the last training was carried out in December 2013 and therefore had not been updated in the previous twelve months as recommended by the UK resuscitation council guidelines. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of myocardial infarction (heart attack), anaphylaxis (severe allergic reaction) and angina (chest pain caused by inadequate blood supply to the heart). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

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

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the lead GP and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP told us he led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions.

The GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for most conditions apart from dermatology which were higher than other local practices. The GP had met with the CCG lead and a GP from another local practice and was investigating the reasons for these high referral rates and looking at ways to reduce them. We found that 90% of standard referrals were made through 'choose and book' and national standards were followed for urgent two week wait referrals for suspected cancer. The GP told us he would safety net patients, that is he would ask them to inform the practice if they had not heard back with an appointment within the two weeks so it could be followed up.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us two clinical audits that had been undertaken in the last year, however neither of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The first audit we reviewed was carried out in July 2014 to identify the number of patients diagnosed with atrial fibrillation (heart condition that causes an irregular and often abnormally fast heart rate) who were also prescribed warfarin (warfarin reduces the risk of stroke in patients with atrial fibrillation). The audit showed that 25 out of 29 patients identified were on warfarin and the remaining four patients had specific reasons recorded in their notes why they were not on warfarin. The practice collected data a second time in April 2015 and found 21 out of 29 patients with atrial fibrillation on warfarin and again there were specific reasons why the remaining eight patients were not on warfarin. We found that although this audit involved data collection and analysis, there was no comparison of the results to any standards and no changes implemented as a result. The second audit we reviewed was carried out to identify patients at risk of calcium and vitamin D deficiency. The results showed that three at risk patients were identified and considered for treatment. There was no evidence of re-audit and the audit was carried out by an external company rather than by practice staff.

The practice had achieved 97% overall in their Quality and Outcomes Framework (QOF) performance in 2013/14, which was 6% above the local CCG average and 4% above the National average (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice scored above the local CCG/National averages for the management of most clinical indicators including those for asthma, atrial fibrillation, cancer, chronic kidney disease, diabetes and hypertension.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly

Requires improvement

Are services effective?

(for example, treatment is effective)

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

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area although dermatology referrals and outpatient attendances were high. We saw minutes from monthly CCG benchmarking meetings where referral rates and outpatient attendances had been discussed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses. For example non-clinical staff had not received training in child protection and safeguarding adults and all practice staff had not completed basic life support (BLS) since December 2014. (The UK resuscitation council guidelines recommend BLS training to be updated annually). All staff had completed training in infection prevention and control.

An induction programme was in place for all new starters including locum staff. Topics covered included administrative matters, training and health and safety including fire safety. A locum folder was in place with detailed guidance for locum staff. Information included safeguarding contact details, infection control procedures and guidance for the management of medical emergencies.

There was a good skills mix amongst clinical staff with the lead GP having a special interest in emergency and urgent care medicine and the nurse having recently qualified as an independent nurse prescriber. The GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (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).

The nurse undertook an annual appraisal that identified learning needs from which action plans were documented. There was no official appraisal system in place for non-clinical staff. However our interviews with staff confirmed that the practice provided staff with training and development opportunities if they requested.

The practice nurse was expected to perform defined duties and was able to demonstrate that she was trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and providing smoking cessation advice. We saw evidence that the nurse had completed a number of update courses in contraception, immunisations, cervical cytology, family planning and smoking cessation. The nurse also had extended roles, including seeing patients with long-term conditions such as diabetes and was also able to demonstrate that she had appropriate training to fulfil these roles.

Working with colleagues and other services

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

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by the district nurse. We were told that palliative care nurses did not attend these meetings and patients requiring end of life care were managed by the district nurse.

Requires improvement

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 90% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in 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 key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the lead GP liaised with social services, pharmacists, carers and family members

Patients experiencing poor mental health were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us out of 27 patients on the mental health register, 25 had care plans in place. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice had achieved 95% in their QOF performance for public health indicators for 2013/14 which was 2% above the CCG average and marginally below (0.1%) the National average. The practices performance was above CCG/National averages for cardiovascular disease (primary prevention), child health surveillance, contraception, maternity services, and smoking.

We found it was not practice policy to offer a health check with the practice nurse to all new patients registering with the practice. We were told health checks were offered based on risk stratification. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 45% of patients in this age group took up the offer of the health check in 2014/15. The lead GP showed us how patients were followed up immediately if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and two out of three patients on the register were offered an annual physical health check and had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics for these patients. However the practice had not audited the percentage of patients receiving advice who had stopped smoking. The practice's QOF performance for smoking was 95% in 2013/14 which was 1% above both CCG/National averages.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice's QOF performance for cervical screening in 2013/14 was 92% which was 1% above the local CCG average and 5% below the National average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance in the previous year for most immunisations was above average for the CCG, for example 93% of children aged 24 months had received a measles, mumps and rubella (MMR) vaccination compared to the CCG average of 92%. Ninety eight percent of two year old children had received the Meningococcal C vaccination compared to the CCG average of 95% and 98% of one year old children had received the 5 in 1 vaccination (polio, whooping cough, diphtheria, tetanus and H. influenzae type b) compared to the CCG average of 95%. Data showed that the practice's performance for flu vaccinations for 'at risk' groups in the year 2014/15 was 100% for patients with chronic obstructive pulmonary disorder (COPD), 94% for those with coronary heart disease and 91% for those with diabetes.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, a patient questionnaire and the NHS Friends and Family Test (FFT). The evidence from these sources showed patients had mixed opinions in terms of satisfaction with their GP practice. For example, data from the national patient survey showed the practice was rated 'among the worst' for patients who would recommend the practice to someone new in the area with only 54% of patients saying they would recommend the practice compared to the CCG average of 70% and National average of 78%. Patient's rating of their overall experience of the practice as 'very good' or 'fairly good' was 76% which was below the CCG/National averages of 78% and 86% respectively. In contrast, the practice scored above CCG/National averages for its satisfaction scores on consultations with doctors and nurses with 82% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time. Ninety seven percent of respondents had confidence and trust in the last nurse they saw or spoke to which was above the CCG average of 95%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and the majority were positive about the service patient's received from their GP practice. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five comments were less positive with patients expressing dissatisfaction with the waiting time for appointments both when booking and whilst waiting to be seen by the GPs. We also spoke with nine 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice telephone was located away from the reception desk and was shielded by a glass partition which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these as a significant event and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was information in the practice leaflet and notices in the waiting room stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to the practice's zero tolerance policy had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

We reviewed the results of the national patient survey 2014 and found that 64% of respondents said the GP involved them in decisions about their care and treatment and 72% felt the GP was good at explaining treatment and results. Both these results were below the CCG area/National averages of 77% and 82% respectively. In contrast 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

Good

Are services caring?

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

The survey information we reviewed did not assess emotional support provided by the practice to patients. However the patients we spoke with on the day of our inspection and the comment cards we received were consistently positive and highlighted that staff responded compassionately when they needed help and provided support when required. One patient told us that when their relative had terminal illness the practice had been extremely supportive.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations such as carer support groups and cancer support. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. A member of staff told us that condolence cards were sent out to those who were bereaved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The lead GP told us that the practice engaged regularly with the local GP network and the Clinical Commissioning Group (CCG) through monthly meetings which he attended with GPs from other practices to discuss local needs and service improvements that needed to be prioritised. The practice had also signed up for the "Productive General Practice (PGP) programme" (an NHS programme which involves program managers coming into the practice and identifying areas of service delivery for improvement).

The practice participated in the unplanned admissions Enhanced Service and used the BIRT 2 tool (Business Intelligence Risk Stratification Tool) to identify patients who were at risk of hospital admissions. The practice had identified 2% of the practice population (72 patients) who were at risk of hospital admissions and care plans were in place to meet their care needs.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example patients were critical of the telephone system as they found it difficult to get through to reception. In response to this the practice upgraded the telephone system to include a queuing system which allowed patients to assess how long they needed to wait to speak with the receptionist. Appointment availability was also highlighted by the PPG as an area needing improvement. In response to this the practice had introduced additional appointment slots.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example longer appointments were available for patients with learning disabilities, older patients, those experiencing poor mental health and patients with long-term conditions. The practice had an open door policy and saw homeless people and asylum seekers as temporary residents.

The practice had access to online and telephone translation services and staff spoke a number of languages including Arabic, Hindi and Urdu.

Staff we spoke with confirmed that they had not completed equality and diversity training but were able to describe various forms of discrimination and recognised the importance of respecting each patient individually irrespective of their colour, race or ethnicity. There was an equality and diversity policy for staff to reference in a folder at reception.

The premises and services had been adapted to meet the needs of patient with disabilities. This included a ramp at the main entrance for wheelchair and mobility scooter access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A hearing loop was available at reception for those patients who were hard of hearing.

Access to the service

Appointments were available Monday to Friday between 8.00 am to 1.30 pm and 5.00 pm to 7.30 pm except Wednesday when the practice closed at 7.00 pm and Thursdays when the surgery closed at lunchtime. Nurse appointments were available most weekdays.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available on request and the practice provided services to a care home in the local area.

The results of the national patient survey 2014 showed a mixed response in relation to patient's satisfaction with access to the practice. For example only 58% of

Good

Are services responsive to people's needs?

(for example, to feedback?)

respondents were satisfied with the surgery's opening hours and 57% of respondents found it easy to get through to the practice by phone. These results were below the CCG average of 70% and 74% respectively. However, results showed that 80% of respondents usually waited 15 minutes or less after their appointment time to be seen which was well above the CCG average of 65%.

Patients we spoke with were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said there was good continuity of care with a preferred GP. This aligned to the national patient survey where 66% of respondents with a preferred GP usually get to see or speak to that GP which was above the CCG average of 57%. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours on most weekdays was particularly useful to patients with work commitments. This was confirmed by patients we spoke with.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system including notices in the waiting room, information in the practice leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received one formal complaint in the last 12 months and found it had been satisfactorily handled and dealt with in a timely way. The complaint had been recorded as a significant event and we saw evidence of it been discussed with relevant staff and learning shared.

Are services well-led?

Good

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

Our findings

Vision and strategy

The lead GP told us that his vision for the practice was to become a GP training practice. The GP had qualified as a GP trainer but had not been approved to provide training which depended on moving to more spacious premises, however the practicalities of moving premises set limits on the practice achieving this. The vision did not incorporate the improvement of the quality of patient care and nothing had been formalised or shared with staff.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff we spoke with knew how to access these policies and a number of policies were available in a folder kept at reception for staff to access. We looked at eight of these policies and procedures and found that they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the lead GP was the lead for safeguarding, QOF and information governance. The practice manager was the lead for health and safety and human resources/recruitment. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action agreed to maintain or improve outcomes. For example the practice's QOF performance in asthma and chronic obstructive pulmonary disorder (COPD) in 2012/13 was below the CCG and National averages. To improve performance the practice decided to run a Saturday clinic for these patients and as a result the practice maximised their QOF performance in asthma and COPD in 2013/14.

The practice provided us with examples of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, clinical audit was limited, there was no evidence of completed audit cycles and clinical audit was not carried out in a systematic way to improve the quality of care for patients.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example a fire risk assessment had been carried out to assess the risks associated with fire.

Leadership, openness and transparency

We saw from minutes that team meetings were held weekly which most staff attended. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff told us they felt supported in their job role. The lead GP told us the practice held monthly governance meetings where performance, quality and risk issues were discussed, however meeting minutes were not available to confirm this.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including disciplinary and sickness policies which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the Friends and Family Test (FFT), patient questionnaires and oral recommendations. We saw an action plan formulated from these sources of feedback which highlighted that waiting times to get an appointment were too long. The practice had taken action by introducing more appointment slots.

The practice had a patient participation group (PPG) which had been established for 15 months. The PPG included representatives from various population groups which included working age patients and older patients and the practice advertised for new members through a notice displayed in the patient waiting room. The PPG met every

Are services well-led?

Good

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

quarter to give feedback to the practice and discuss areas for improvement. As a result of PPG feedback the practice had made improvements to the telephone system and appointment system.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place for clinical staff however there were no appraisals in place for non-clinical staff. However, staff told us that the practice was very supportive of training. For example one staff member we spoke with was given the opportunity to go on care plan training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.