

Dr Ashraf Bakhat

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?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	9
Areas for improvement	9

Detailed findings from this inspection

Our inspection team	11
Background to Dr Ashraf Bakhat	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13
Action we have told the provider to take	25

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Bakhat on the 21 July 2015. Overall the practice is rated as requires improvement. Specifically, we found the practice to require improvement for providing safe and well led services. It was good for providing an effective caring and responsive service.

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

- The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. However, no record was kept of discussions that took place about the analysing of incidents.
- Safeguarding policies and procedures were available for staff to refer to when necessary. Further safeguarding training was planned for a number of clinical and non- clinical staff.
- Information about services and how to complain was available.

- Potential risks to the service were anticipated and planned for in advance.
- Staff were supported with their training and learning development.
- The practice worked with other agencies and professionals to support continuity of care for patients
- Patients said they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- Most staff considered there to be an open culture within the practice, and they had the opportunity to raise issues during team meetings.

Importantly the provider must:

- All staff should be provided with the appropriate level of safeguarding training for their role. A record should be kept of meetings held in relation to patient safeguarding concerns.
- Ensure medicines are managed safely including improvements to the process for dealing with medicine alerts and the security of prescriptions.

Summary of findings

- Ensure governance systems bring about improvements to the running of the service.

In addition the provider should:

- Improve the way significant events and incidents are recorded and keep a hard copy of this information to demonstrate and support staff learning and improvement of patient outcomes.
- Improve the process for deciding which audits are completed and consider involving the whole clinical staff team in any decisions.
- Improve the process for auditing alerts that come into the practice and consider appointing a member of staff to take responsibility for disseminating these alerts. An audit trail of all alerts received should be kept.

- Provide staff with chaperone training as necessary.
- Establish a cleaning schedule for the equipment used by clinical staff.
- Provide staff with an annual appraisal of their work.
- Improve systems for keeping clinical staff informed about patients' care needs.
- Provide staff with training on the Mental Capacity Act and patient consent to treatments.
- Improve the documentation kept in relation to the management of complaints.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. The practice provided evidence for monitoring safety issues and equipment was in place to deal with emergencies. Further staff training was planned on patient safeguarding. Medicine management should be improved. Although, recruitment checks were carried out, some records were incomplete.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff worked with other health care teams. Staff had received a range of training appropriate to their roles. Referrals to other services were made, and patients with long-term or chronic conditions were monitored to ensure their on-going good health. NHS health checks were available and opportunistic health care advice was provided during consultations.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients' views gathered at inspection demonstrated they were treated with dignity and respect and they were involved in decisions about their care and treatment. We saw that staff treated patients with kindness and respect, and maintained confidentiality. Patients were supported with their emotional care and treatment.

Good



Are services responsive to people's needs?

The practice is rated as good for providing a responsive service. Referrals were made to local support groups for patients who misused substances or alcohol. The practice monitored A&E attendance, as well as missed appointments. An interpreter service was used for patients who did not speak English. Extended appointment times were available. The telephone triage system directed patients to the 'minor ailments scheme'. This service is based at a local pharmacy and is set up to support patients with minor conditions. Patients told us they found it difficult to book an appointment, particularly an emergency appointment.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led. The staff spoken with said they were happy working at the practice and felt well supported in their role. There was a lack of clarity about

Requires improvement



Summary of findings

the overall governance at the practice. We found that some systems needed to be more robust with regard to recording and sharing information, ensuring effective systems for monitoring and reviewing performance and future planning of the service.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as requires improvement for the care of older people. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice offered advice on health promotion. Patients over the age of 75 years were offered a variety of health checks including breast and bowel screening, blood pressure tests and diabetes and cardiovascular risk assessments. Flu, pneumonia and shingles vaccinations were given. Memory screening assessments were completed along with asthma checks. Home visits were carried out by a variety of members of the clinical team to monitor patients with chronic disease or assess acute illness.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the care of people with long term conditions. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Patients' with long-term conditions were regularly monitored to minimise emergency hospital admissions. The practice aimed to provide patients with a named GP to ensure continuity of care. Staff worked with outside agencies to ensure patients were supported and received high quality care within the community. Patients were provided with literature and support so they were equipped to manage their conditions appropriately. For example, patients with COPD were given self-management plans and rescue packs of antibiotics in case of exacerbation at home. Patients were provided with on-going emotional, social and psychological support to improve their quality of life. Patients' repeat prescriptions were monitored to ensure they met their changing health care needs

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Staff worked with other healthcare professionals to ensure continuity of care. Patients were provided with information about children's health in relation to chronic diseases. Contraceptive advice, cervical screening and breast assessment was available for female patients through GP and Nurse

Requires improvement



Summary of findings

consultations. Childhood vaccinations were available along with flu and pneumonia vaccinations for at-risk groups. Travel advice and vaccines were available along with advice on how to give up smoking.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice offered telephone consultations every day as well as pre-bookable appointments for morning and afternoon surgeries. Pre-bookable late evening appointments were available along with a surgery on a Saturday morning. Appointments and prescriptions could be made and ordered on-line, and telephone consultations were available with the GPs.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The IT system identified patients who were deemed vulnerable. The practice had links with children and adult safeguarding services. Staff worked with patients and carers to help reduce and manage any identified risks. The practice monitored A&E attendance, as well as missed appointments. The practice safeguarding policy was kept up to date, although some staff were not up to date with safeguarding training. Annual health checks are available to patients with a learning disability in order to maintain communication improve health outcomes and identify early medical conditions.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as requires improvement for safety and for well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice staff recognised the significant impact poor mental health can have on patients' everyday life. Same day or longer appointments were offered to patients with more complex problems. GPs monitored patients who did not attend for follow-up appointments to manage the risk of increased poor health. Staff contacted patients with poor

Requires improvement



Summary of findings

memory to remind them of appointments and regularly review these patients with the same GP to promote continuity of care. Referrals were made to community drug and alcohol workers for those patients with problems relating to drug and alcohol abuse. Assessments were carried out for the early identification of dementia, and if required, a referral to memory clinic services was made.

Summary of findings

What people who use the service say

We looked at 23 CQC comment cards that patients had completed prior to the inspection and spoke with 11 patients.

Patients spoken with were very positive about the care they received. They commented that they felt safe when they visited the practice. Patients told us they were asked for their consent before treatments were given, and the GP or nurse provided them with information about how to manage their own health care issue. Patients reported they were treated with dignity and respect. They said their GPs and nurse listened to what they had to say, and referrals to secondary care were carried out promptly. Patients were generally happy with the system in place for ordering repeat prescriptions. Patients told us they had enough time to discuss their care needs during consultations and that clinical staff explained their treatments and the risks involved. A couple of patients felt they were rushed during consultations. Three patients said they found it difficult to book an appointment, particularly an emergency appointment, although this was not the case for babies and children. Patients who had suffered a bereavement said they were well supported by the GPs and staff team.

Patient feedback on the comment cards we received was complimentary about the staff and the service provided. Patients reported the reception staff were friendly and helpful, and they described the GPs as excellent and caring. Patients commented that they were treated with respect. Overall patients were very happy with the standard of care and treatment they received. Four patients commented they found it difficult to book an appointment.

We looked at the results of the National GP Patient Survey, which is an independent survey run by Ipsos

MORI on behalf of NHS England. The results show how people feel about their GP practice and were compared to the local Clinical Commissioning Group (CCG) average. The latest results published in July 2015 indicated the following:

What the practice does best:

88% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern. Local (CCG) average: 90%.

94% of respondents had confidence and trust in the last nurse they saw or spoke to. Local (CCG) average: 97%.

85% of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments. Local (CCG) average: 89%.

What the practice could improve:

28% of respondents find it easy to get through to this surgery by phone. Local (CCG) average: 67%.

29% of respondents with a preferred GP usually get to see or speak to that GP. Local (CCG) average: 58%.

41% of respondents describe their experience of making an appointment as good. Local (CCG) average: 69%.

We looked at the information gathered from the Friends and Family test carried out between February and July 2015. This patient survey asks patients how likely they were to recommend the surgery and services to friends and family. 78% of patients indicated they would recommend the practice to friends and family. 17% said they would not recommend the practice, and 5% responded they didn't know.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff are provided with the appropriate level of safeguarding training for their role. A record should be kept of meetings held in relation to patient safeguarding concerns.

- Ensure medicines are managed safely including improvements to the process for dealing with medicine alerts.
- Ensure governance systems bring about improvements to the service.

Summary of findings

Action the service **SHOULD** take to improve

- Improve the way significant events and incidents are recorded and keep a hard copy to demonstrate and support staff learning and improvement of patient outcomes.
- Improve the process of deciding which audits are completed and consider involving the clinical staff team in any decisions.
- Improve the process for auditing alerts that come into the practice and considering appointing a member of staff to take responsibility for disseminating these alerts. An audit trail of all alerts received should be kept.
- Provide staff with chaperone training as necessary.
- Establish a cleaning schedule for the equipment used by clinical staff.
- Provide all staff with an annual appraisal of their work.
- Improve systems for keeping all staff fully informed about patients' care needs.
- Provide staff with training on the Mental Capacity Act and patient consent to treatments.
- Improve the documentation kept in relation to the management of complaints.

Dr Ashraf Bakhat

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP, a practice nurse and an expert by experience. Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services.

Background to Dr Ashraf Bakhat

Dr Ashraf Bakhat surgery is based in Wythenshaw, Manchester. The practice treats patients of all ages and provides a range of medical services. The staff team includes one principle GP (male) and five salaried GPs (3 male and 3 female). There are two practice nurses. The practice is a training practice and on the day of the inspection there were three trainee GPs present. The administration team consists of a practice manager, an assistant practice manager/secretary and six reception staff.

The practice is open Monday to Friday from 8.30am to 6.00pm. Patients can book appointments in person, on-line or via the telephone. The practice provides telephone consultations, pre-bookable consultations, same day (advanced access) appointments and home visits to patients who are housebound or too ill to attend the practice. The practice closes from 1.00pm to 3.00pm every Weds afternoon for staff training. When the practice is closed patients access an out of hour's provider by ringing the normal surgery telephone number.

The practice is part of South Manchester Clinical Commissioning Group. It is responsible for providing primary care services to approximately 8509 patients. The practice has a General Medical Services contract.

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

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:

Detailed findings

- 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 our inspection, we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We also reviewed

policies, procedures and other information the practice provided before the inspection. This did not raise any areas of concern or risk across the five key question areas. We carried out an announced inspection on 21 July 2015.

We reviewed the operation of the practice, both clinical and non-clinical. We observed how the staff handled patient information and spoke with 11 patients. We reviewed a variety of documents used by the practice to run the service and discussed how GPs made clinical decisions. We looked at survey results and reviewed CQC comment cards left for us on the day of our inspection. We spoke with the principle GP, a salaried GP, a trainee GP, the practice manager, 2 practice nurses and administrative staff.

Are services safe?

Our findings

Safe track record

South Manchester Clinical Commissioning Group and NHS England reported no concerns to us about the safety of the service. The practice was aware of the need to report specific issues to the Care Quality Commission and gave examples of changes in partnership or services offered.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. GPs met daily to discuss any incidents and issues that arose from the practice. However, no record was kept of discussions that took place about the analysing of incidents. There were no paper copies of significant events available although we did see a brief summary of a small number of significant events that had taken place. This issue was discussed with the GP, who agreed that they were likely to under report incidents. There was evidence to demonstrate the summaries had been discussed at more formal clinical meetings, and learning and improvement were evident. However, one clinical staff member said they were not always informed of serious incidents or complaints. The GP was aware that improvements needed to be made in this area as there was no clear method of disseminating learning other than the quarterly meetings.

Learning and improvement from safety incidents

A new system for reporting incidents had recently been introduced by the Clinical Commissioning Group. This electronic reporting system called Datix had only been used for the previous two weeks. All incidents were now being reported through this system.

Clinical audits were completed although this was not done in an organised manner, rather GPs conducted audits in areas of their own interest. The GP had conducted a recent full audit cycle into Type 2 diabetic patients looking particularly at the use of a specific medicine. Improved outcomes for patients resulted from switching patients to alternative medicines.

A second example of a full audit cycle was initiated in response to changes in recommendations from National Institute of Health and Clinical Excellence in June 2014 for

patients with atrial fibrillation. The practice looked at all patients in this group and changes were made to medicines provided. This clearly demonstrated improved patient care.

There was no audit trail of alerts coming into the practice. No one in the practice was responsible for collating alerts and ensuring staff were informed, rather staff were responsible for their own response to alerts.

The GP showed us two examples of alerts they had received and considered. The first related to advice from the local Clinical Commissioning Group advising GPs to be aware of patients who may be traveling abroad for Female Genital Mutilation and the second about the use of synthetic cannabis. Both alerts were logged on the computer system.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures were available for staff to refer to when necessary. One of the GPs took the lead role in managing patient safeguarding but no GP took responsibility for incident reporting. Their role included providing support to their practice colleagues for safeguarding matters.

Safeguarding training in adults and children was available to staff although not all staff were trained in both areas. A member of the clinical staff had not completed training in safeguarding for 4 years. Only one GP was trained to level 3 in safeguarding children, although this was not the GP who took responsibility for managing safeguarding matters. This issue was recognised by the practice staff and GPs were now working towards safeguarding training at level 3. We were informed that safeguarding training was being provided to staff within the next couple of days.

GPs met daily to talk about concerns relating to patients. One of the GPs took responsibility to obtain information about these concerns, although no minutes were kept of these meetings.

No formal multi-disciplinary team meetings took place. We were informed that palliative care meetings regularly took place, and safeguarding issues were discussed. These concerns were also discussed between GPs at daily meetings. Practice nurses did not attend these meetings due to other work commitments and clinics, although they expressed an interest in doing so.

Are services safe?

Staff knew to report a safeguarding concern to a senior member of staff or one of the GPs, although not everyone knew which GP took the lead on managing safeguards in the practice. Staff spoken with had a basic understanding of the different types of abuse that could take place, and they knew to report their concerns promptly.

Children's attendance at vaccination clinics was monitored with a record of this information kept. If children did not attend for vaccinations, then a recall letter is sent out. Children's attendance at A&E was monitored, with an A&E attendance record being submitted which identified excessive attendances.

A system was in place to monitor children who did not attend appointments. When the risk of harm or actual harm had been identified, staff would notify the relevant services and when necessary, the psychiatric crisis team. Staff responded promptly to concerning behaviour such as school difficulties and behavioural problems with prompt referrals made to Social Services to share information.

The practice offered patients a chaperone prior to any examination or procedure. (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). Information about a chaperone was displayed in the patient waiting area and in consulting rooms. Most patients spoken with said they were not offered a chaperone as it was not necessary during their consultation. Two patients said they had been offered a chaperone. Some staff reported they had not been provided with chaperone training and were not aware of the chaperone policy.

Medicines management

Medicines were stored securely in a locked room. All fridges were kept at the right temperature. Only one fridge was hardwired to the mains electricity. Medicines were regularly checked. However, not all the necessary information was recorded to complete full audits. For example, checks did not indicate the contents of the fridge, the stocks of medicines added to the fridge, and medicine expiry dates.

The vaccine fridge was kept at the correct temperatures and was only used to store vaccines. The fridge's electrical safety was tested in May 2015. Vaccines were stored in the original boxes. Guidelines for the administration of vaccines were not in place. Staff who administered vaccines were trained and completed annual updates, the

last being in May 2015. No checks were kept on the vaccine expiry dates. Only the practice nurses were responsible for ordering vaccines. Staff knew to reset the temperature of the fridge in case it dropped while restocking. The fridge did not have two thermometers. A check was completed to ensure the calibration of the fridge was correct.

Both practice nurses were qualified to prescribe medicines for long-term care. They were provided with informal supervision for this role from one of the GPs and a community pharmacist. They attended the Practice Nurse Forum, so they were updated on matters relating to their role.

The practice received regular medicines management alerts which clinical staff were informed about via email. Practice nurses only received alerts relevant to their area of authority. Evidence was in place to demonstrate actions taken in relation to two of these alerts to improve patient outcomes.

There was no clear system in place to ensure all patients received an annual review of their medicines which meant there was a risk of some patients being missed. Reviews were carried out opportunistically during consultations. All hospital discharge letters prescriptions and discharge summaries were reviewed daily by the GPs who then made relevant changes to medicines.

The room where prescriptions were stored was not locked as it was used daily for other administrative purposes. Prescriptions were stored in printers in clinical rooms which we observed were not always locked after use which increased the risk of prescriptions being stolen. The prescription box numbers were logged so they could be audited for safety reasons. A full clinical audit cycle had taken place in relation to the management of prescriptions. This had resulted in a system being set up so that GPs could quickly address any queries that arose. The patients spoken with told us they were happy with the way their prescriptions were handled.

In the light of these issues, the practice must improve the way they manage medicines within the practice.

Cleanliness and infection control

Patient feedback on the CQC comment cards we received was positive about the standard of cleanliness throughout the building.

Are services safe?

There were effective systems in place to reduce the risk and spread of infection. The practice had completed an infection control audit. The issues identified as needing attention had been addressed.

Clinical rooms were fit for purpose. Floor covering was waterproof and disposable curtains were in place to minimise the spread of infection. The building maintenance company was responsible for the general cleaning of the practice. There were hand washing facilities in the clinical rooms and hand wash and alcohol gel available with disposable paper towels. The practice nurses were aware of the waste disposal system. Bins were foot operated, and a contractor removed clinical waste and sharps boxes.

A cleaning equipment schedule was not in place. We noted that equipment was cleaned with the correct cleaning tablets, but a record of the cleaning was not documented. The practice used single use disposable equipment for all procedures, for example, minor surgery/spirometry and cervical smears. Equipment was not sterilised on the premises.

Reception staff spoken with said they were trained in infection control procedures in February 2015. We were unable to establish whether staff had received the Hepatitis B vaccination as records were not up to date.

Equipment

The practice had the equipment it needed for the care and treatments provided. The building was managed by a building maintenance company which took responsibility for fire safety checks and risk assessments, the testing of water temperatures and legionella etc. Medical equipment such as blood pressure monitors, baby scales, and ear syringes were calibrated to ensure they were safe to use. Portable equipment was tested for its electrical safety.

Resuscitation equipment was stored in different parts of the practice rather than on a trolley in one place. For example, oxygen was stored in the nurse's room and the community room, the defibrillator in the reception and adrenaline in the nurse's room and stock room fridge.

Staffing and recruitment

The staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. Staff sickness and holidays were covered by the existing staff team which provided continuity of service.

There had been few changes to the practice staff team over recent years and the GPs and other members of staff took the lead in respect of a range of clinical and non-clinical areas, which provided patients with a continuity of service delivery.

The practice had a recruitment procedure that outlined the checks that were needed prior to the employment of staff. For example, obtaining references, checking qualifications and professional registrations and carrying out Disclosure and Barring Service (DBS) check (these checks provide employers with an individual's full criminal record and other information to assess the individual's suitability for the post). We looked at the recruitment records of three staff. Most of the necessary information was in place to demonstrate staff were suitable for their role. Staff references were in place along with a DBS checks.

Induction training was provided for clinical and non-clinical staff to ensure they were aware of their responsibilities and knew what was expected of them. Senior staff were always available to support staff during their probationary period, and disciplinary procedures were in place to manage staff that were no longer suitable for their role.

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. The practice used an IT record system that was password protected. Health and safety information was displayed. Fire safety was the responsibility of the building management company who provided the practice with health and safety information. Patients who became housebound were offered home visits, and there was a recall system for annual reviews and other monitoring for patients with chronic diseases and long-term conditions. Arrangements were in place to supervise / support locums. They were given an information pack so they were updated on the working of the practice.

Arrangements to deal with emergencies and major incidents

Potential risks to the service were anticipated and planned for in advance. The practice had access to oxygen in the event of an emergency, and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) was available. Staff were trained in dealing with medical emergencies including basic life support skills and how to manage patients who present with challenging

Are services safe?

behaviours in the form of verbal or physical aggression. Fire safety training had been undertaken, and fire alarm tests were regularly completed. An urgent alert could be activated through the IT system to call for the assistance of other staff in case of an emergency.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included information about the loss of utilities such as gas and power, adverse weather, unplanned sickness and access to the building. The

document also contained relevant contact details for staff to refer to. The plan did not include emergency contact details for utility providers or that the building was managed by a management company that may take responsibility for overseeing a significant event.

Changes in demand for the service such as sickness and holidays were managed through the provision of an additional GP who took calls in the morning and could, if necessary, take on a full surgery as needed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff told us they were open about asking for and providing colleagues with advice and support. GPs told us they supported all staff to review continually and discuss new best practice guidelines for the care of patients' different health care needs.

Long term and chronic conditions were assessed and managed through the appointment recall system. This area of work was led by GPs. Patients' with long-term conditions were regularly monitored to ensure a good quality of life and to minimise emergency hospital admissions. The practice aimed to provide the patients with a named GP to ensure continuity of care.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included scheduling clinical reviews and monitoring patients with long-term conditions. The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of care and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. QOF data from 2013/2014 showed the practice was performing about average when compared to other practices nationally. The practice performed about average in maintaining a register for patients with a learning disability, a register of patients in need of palliative care and support and having regular multidisciplinary reviews of patients on the palliative care register.

Patients who did not attend appointments were contacted with a further appointment offered. Patients with a learning disability had an enhanced service. They had an annual review with their carer if necessary. Home visits are carried out by a variety of members of the clinical team to monitor chronic disease or assess acute illness.

Patients who were a high risk of admission into hospital were identified and selected for care planning. Their care needs were reviewed every three months. Care plans were discussed and agreed with patients and carers as appropriate.

Effective staffing

We were informed an appraisal system was in the process of being developed for non-clinical staff. The purpose of this was to review staff performance and identify staff development needs for the coming year. Practice nurses did not have an appraisal of their work. GPs did not have in-house appraisals but relied on the General Medical Council for annual appraisals and revalidation. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The practice GP was validated in October 2014 their next appraisal will be October 2015.

Staff spoken with told us senior staff were supportive of their learning and development needs and they felt well supported in their roles. They said they had undertaken the training needed for their roles. Staff were given a handbook which provided them with information about staff working conditions and how to raise a safeguarding concern. The practice had recently invested in an online training academy for staff.

The practice manager acted as a non-clinical cancer champion. Their role ensured a smooth care package and a point of contact for patients diagnosed with cancer. Practical advice was given about prescriptions and financial matters, and support was given around attending appointments. This member of staff attended the palliative care meetings and had a link to the district nurse to keep them informed of issues relating to patient care needs.

Working with colleagues and other services

Staff were involved in assessing, planning and delivering people's care and treatment. The Gold Standards Framework was in place, and meetings were held every month to share information and ensure all relevant health care professionals were kept informed of patient care issues. The meetings were attended by GPs, district nurse, palliative nurse. A record of these meeting was kept. Clinical staff met with the local Clinical Commissioning Group to discuss local area needs and to be updated of developments in the local area. There were clear

Are services effective?

(for example, treatment is effective)

arrangements for referrals to other services. An alcohol worker from a community support group held a clinic at the practice each week, and referrals were made to other services such as counselling and drugs services.

Information sharing

The practice used electronic systems to communicate with other providers. Reception staff were trained in the use of the IT systems. Staff knew to keep information about patients confidential. Staff knew they could only share information about patients with other family members or carers upon the patient's agreement. A confidentiality policy was in place, and information about patients was stored securely. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system (EMIS) to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference.

Regular meetings involving the practice manager and non-clinical staff took place to ensure staff were fully informed about the systems in place for the running of the service. GPs met regularly to discuss information about risks, significant events, and patient care issues were discussed to ensure all staff had all the information they need to deliver effective care and treatment to patients. Practice nurses were not involved in these meetings so did have the opportunity to be updated on issues discussed.

Staff shared information with the out of hour's provider so they were fully informed about patients' needs during the out of hour's period. This enabled continuity of care for patients with a terminal illness or complex mental health issues.

Consent to care and treatment

There was no policy guidance on the use of the Gillick competencies which help clinicians to identify young people (aged under 16) who have the legal capacity to consent to medical examination and treatment. The use of these principles was decided by the individual GP.

Patients spoken with said they were asked for their consent to treatments when necessary.

We spoke with clinical staff about their understanding of the Mental Capacity Act (MCA) 2005. The GP was aware of principals relating to the MCA and gave an example of a patient who lacked capacity and subsequent deteriorating health. Practice nurses had not been provided with recent training in the MCA or consent and said they would speak to a GP if any concerns arose.

GPs obtained written consent for minor surgery. If a patient was unable to make decisions for themselves, then best interest decisions were recorded in patients' notes. No examples of this were identified.

Health promotion and prevention

NHS health checks were available although there was a low uptake of these checks. Consequently, they were not carried out routinely. Staff addressed this through opportunistic care. Flu, pneumonia and shingles vaccinations were available to patients over 65 years of age. Contraceptive advice was available for female patients through GP and practice nurse consultations. Pre-pregnancy counselling and vaccinations were provided along with antenatal care from the GPs and midwives. Patients over 75 years of age were offered a variety of health checks and breast screening was available for patients from age 49 to 73 years of age.

Health promotion leaflets and posters were displayed in the patient waiting area. For example, information was available about ovarian cancer, meningitis, dementia and testing of sexually transmitted infection. Information was also available about local services such as drug and alcohol, counselling, mental health, and bereavement. There was no information available about what patients should do if they had concerns about the safety of another adult or a child. None of the information was in different languages.

Travel advice and vaccines were available along with advice on how to give up smoking.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The reception area was not segregated from the administration area so conversation could easily be overheard. Reception staff were aware of the open plan arrangement, and we observed staff interacted with patients respectfully and quietly when speaking with them on the phone or directly when they came into the surgery.

Feedback on the patient comment cards we received was very positive about the service. Patients commented they received a good service and found the staff friendly and caring. They noted that the clinical staff were compassionate and provided excellent treatments. Patients noted they were always treated with respect.

Patients spoken with said they were always treated with dignity and respect. They described the staff as, fine, friendly and helpful.

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice compared to the local Clinical Commissioning Group average. The latest results published in July 2015 indicated the following:

74% say the last GP they saw or spoke to was good at treating them with care and concern. Local (CCG) average: 85%.

82% say the last GP they saw or spoke to was good at listening to them. Local (CCG) average: 90%.

88% of respondents say the last nurse they saw or spoke to was good at treating them with care and concern. Local (CCG) average: 90%.

85% of respondents say the last nurse they saw or spoke to was good at explaining tests and treatments. Local (CCG) average: 89%.

The practice staff recognised the significant impact poor mental health can have on patients' everyday life. They aimed to have a dedicated mental health lead GP in place and offer patients with more complex problems same day or longer appointments. The practice took a holistic approach to helping improve patients' mental health as well as monitoring their physical health and social circumstances.

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

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

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice compared to the local Clinical Commissioning Group average. The latest results published in July 2015 indicated the following:

74% say the last GP they saw or spoke to was good at involving them in decisions about their care. Local (CCG) average: 84%.

80% say the last nurse they saw or spoke to was good at involving them in decisions about their care. Local (CCG) average: 85%.

87% say the last nurse they saw or spoke to was good at giving them enough time. Local (CCG) average: 92%.

78% say the last GP they saw or spoke to was good at explaining tests and treatments. Local (CCG) average: 87%.

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

Patient/carer support to cope emotionally with care and treatment

Patients and those close to them received the support they needed to cope emotionally with their care and treatment. The telephone triage service allowed for a quick response

Are services caring?

to patients who felt their mental health was deteriorating, or they were at crisis point. Longer appointments were offered when needed. Bereavement counselling services

were available for family members, and carers and staff would direct them to care support agencies as required. Patients who had suffered a bereavement said they were well supported by the GPs and staff team.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There were systems in place to address the identified needs of the practice population. Patients under five years of age are seen on the same day and elderly patients even if there are no appointments. The practice offered telephone consultations every day as well as pre-bookable appointments for morning and afternoon surgeries. Appointments and prescriptions could be made and ordered online, and telephone consultations were available with the GP from Monday – Saturday. There was a register of housebound patients, and regular home visits were made as required.

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice compared to the local Clinical Commissioning Group average. The latest results published in July 2015 indicated the following:

63% describe their overall experience of this surgery as good. Local (CCG) average: 83%.

48% would recommend this surgery to someone new to the area. Local (CCG) average: 76%.

Tackling inequity and promoting equality

The services provided took account of the patients' different needs. For example, referrals were made to local support groups for patients who misused substances or alcohol. The practice monitored A & E attendance, as well as missed appointments. We were informed that some patients do not speak English. A patient interpreter service was used, and double appointments were booked for this purpose. Facilities were in place to support patients with disabilities. For example, there was level access leading up to automatic doors at the entrance, and disabled parking was available in the car park. There was a disabled toilet available along with baby changing facilities. 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. It was identified that patients with a learning disability could suffer from poor health. Annual health checks were available for these patients in order to maintain communication, improve health outcomes and identify early medical conditions.

Access to the service

Patients could access care and treatment in a timely way for diagnosis and for treatment or on-going management of health conditions. Appointments were available from 8 am to 6 pm from Monday to Friday. With late night opening on a Thursday until 7.30 pm. The practice was open

From 8.30 am until 12 noon on a Saturday morning. The practice is closed between 1-3 pm on a Wednesday. When patients contact the surgery at this time, a number is given as to who they should contact in an emergency. Appointments could be booked two weeks in advance. Two GPs were available for telephone consultations every Monday. One GP was on call from 1pm each day to deal with emergencies, for example, children and babies, patients over 75 years of age and unplanned admissions into hospital. The telephone triage system may direct patients to the 'minor ailments scheme'. This service is based at a local pharmacy and is set up to support patients with minor conditions. Telephone consultations and home visits were available, and information about how to book these appointments was on the practice 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.

Patients spoken with said they found it difficult to book an appointment, particularly an emergency appointment, although this was not the case for babies and children.

A practice leaflet was available and provided patients with information about how they could access the practice. For example, the practice opening times, staff details, who to contact in an emergency and the complaint procedure. The practice leaflet was kept behind the reception desk, and patients would have to speak to a member of staff if they wanted a copy.

Urgent referrals are made during consultations on the two-week system. This referral time period was logged on the IT system, and a member of the administration staff tracked the referrals to ensure they were actioned.

We looked at the results of the National GP Patient Survey which is an independent survey run by Ipsos MORI on

Are services responsive to people's needs?

(for example, to feedback?)

behalf of NHS England. The results show how people feel about their GP practice and were compared to the local Clinical Commissioning Group (CCG) average. The latest results published in July 2015 indicated the following:

28% find it easy to get through to this surgery by phone.
Local (CCG) average:67%.

29% with a preferred GP usually get to see or speak to that GP. Local (CCG) average:58%.

86% say the last appointment they got was convenient.
Local (CCG) average:92%.

41% describe their experience of making an appointment as good. Local (CCG) average:69%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaint policy and procedure were available on the practice website and in the practice leaflet, though not in the patient waiting area in the surgery. One of the GPs was responsible for managing complaints, with the practice manager being the designated contact person. Staff were clear on the action they would take if they received a complaint. They knew to give patients a copy of the complaint procedure, so they were aware of timescales for the investigation of their complaint. We were informed that complaints were investigated with patients responded to in a timely manner. However, records looked at did not hold information to demonstrate this had taken place with only minimal information being kept about the complaint details.

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 practice aimed to 'Treat patients with courtesy, respect and dignity at all times irrespective of their ethnic origin, religious and cultural beliefs, gender, social class, disability or age'.

Areas for the development of the practice had been identified for the next 12 months. These included improvements to recording and sharing information about significant events, staff training, including safeguarding, team working and the introduction of an appraisal system for clinical staff. The principle GP had completed a leadership training provided by the Clinical Commissioning Group to support work in achieving these aims. As yet there was no strategy in place to address how these areas of development would be achieved.

A copy of the practice charter was displayed behind the reception desks. We were told that the vision and values were shared with staff during quarterly meetings which all staff attended. Not all staff were aware of the practice vision and values. Reception staff spoken with said they were clear that patients should be treated with respect and provided with a good service.

Governance arrangements

There was a lack of clarity about the overall governance process in the practice. We found that systems were in place to ensure good communication and that generally, staff support was positive. However, some systems need to be more robust.

The practice had completed clinical audits to evaluate the operation of the service and the care and treatment given. A discussion with the GPs showed improvements had been made to patient care as a result of the audits undertaken. However, they were not done in an organised manner as GPs conducted audits mainly in areas of their own interest.

The practice had systems in place for identifying, recording and managing risks. GPs met daily to discuss any incidents and issues that arose at the practice. However, no record was kept of discussions that took place about the analysing of incidents. There were no paper copies of significant events available although we did see a brief summary of a small number of significant events that had taken place.

Staff took responsibility for overseeing parts of the running of the practice; however there were no specific systems identified for the monitoring and reviewing of performance. For example, clinical audits were completed individually rather than practice wide. One of the GPs took responsibility for staff appraisals, although practice nurses told us they had not had their work and performance appraised for some years.

Leadership, openness and transparency

Most staff considered there to be an open culture within the practice, and they had the opportunity to raise issues during team meetings or as they occurred with the practice manager or one of the GPs. Clinical and non-clinical staff we spoke with said they were very happy working at the practice. Regular governance meetings took place to share information; look at what was working well and where any improvements needed to be made. However, some staff said they were not involved in these meetings and feedback was not always provided.

During discussion, GPs demonstrated how they created a culture centred on the needs and experience of patients who used the services.

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

The practice had gathered feedback from patients through the Friends and Family Test, patient surveys and complaints received. We looked at the information gathered from the Friends and Family test carried out between February and July 2015. This patient survey asks patients how likely they were to recommend the surgery and services to friends and family. 78% of patients indicated they would recommend the practice to friends and family. 17% said they would not recommend the practice and 5% responded they didn't know.

The practice did not have Patient Participation Group (PPG). A PPG is a group of people who work with the GPs and staff to improve services and promote health and improve the quality of care. The practice planned to develop the PPG and to date, nine patients had expressed an interest in being part of the group. The practice manager intended to liaise with Clinical Commissioning Group Patient and Public Involvement team to help assist with setting up a successful PPG. Regular meetings would then be held to discuss issues relating to the current and future developments of the practice.

Are services well-led?

Requires improvement 

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

The practice gathered feedback from staff through staff meetings and discussions. Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. However, not all staff attended meetings and told us they were not fully informed about the issues relating the running of the practice.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. This meant they could report their concerns anonymously.

Management and governance of the practice supported learning and improvement although it was recognised that additional training was needed for some staff to ensure they were up to date with current good practice. Protected learning time was available for all staff so they could attend training for their development. Five days a year were provided for clinical and non-clinical staff. GPs had one afternoon each week allocated to training. Systems in place to learn from significant incidents, however, a record should be kept of learning and discussions that take place.

Management lead through learning and improvement

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

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure that care and treatment must be provided in a safe way for service users by: ensuring the proper and safe management of medicines.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must ensure that systems or processes are established and operated effectively to ensure compliance with the regulations in particular: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

All providers must make sure that they have, and implement, robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent.