Dr Muhammad Misbah-Ur-Rehman Siddiqui

Quality Report

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Date of inspection visit: 27th August 2014
Date of publication: 22/01/2015

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

Contents

Overall summary

We completed an announced comprehensive inspection of the service on the 27th August 2014. The practice is

Summary of findings

rated as good overall. This reflects the safety and quality of the provider's provision of care and treatment on offer and the availability of suitable and qualified staff who are responsive to patients' and the local community needs.

Dr Muhammad Misbah-Ur-Rehman Siddiqui provides general practice (GP) services to over 3,300 patients within the Ruislip area of Hillingdon. There are two GPs, one practice nurse, one practice manager, two staff members for reception duties and two administration support staff. The practice is registered for providing the following regulated activities at this location: treatment of disease, disorder and injury, and diagnostic and screening procedures. The practice operates from a converted house with step free and wheelchair access and is situated on a suburban road with restricted parking. The practice is open Monday to Friday with a morning surgery from 09:00 to 12:00 midday and evening surgery from 17:00 to19:30 hours and is closed half a day on Thursdays from 013:30. We carried out an announced inspection on the 27 August 2014. During our inspection we spoke with patients and four members of the Patient Participation Group (PPG) and reviewed 33 Care Quality Commission (CQC) comment cards that had been completed by patients during the two week period prior to our visit. Patient feedback about the care and treatment they received was mainly positive, although some commented negatively about the size of the waiting area, securing an appointment or getting though through to the practice on the telephone to make an appointment.

Our key findings were as follows:

- Arrangements for reporting incidents were in place. Complaints and significant events were recorded and discussed, and learning from them was shared with the practice team. Infection prevention and control policies and procedures were in place and staff had completed infection control training. The provider had adequate staff numbers in place to provide care and treatment to patients.
- Staff were skilled and qualified to do so. There were effective governance arrangements, and systems in place to conduct regular audits and reviews of patient care plans and treatment to support and manage patients in the treatment of disease, disorder or injury effectively.
- Patients were cared for in a kind and compassionate manner, and were treated with dignity and respect at all times. The provider was engaging with the local community and other services and organisations to support and deliver appropriate care to the patient population list.

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

Importantly, the provider must take action to:

- Take action to ensure that at all times, there are sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying out the regulated activity.
- Implement formal procedures for recording and documenting records of all staff meetings and minutes to safeguard internal practice and information challenges.

In addition the provider should take action to:

- Ensure that the practice leaflet is up to date with information on what to do when the practice is closed during the day.
- Make the patient leaflet available within the waiting area of the practice.
- Update the practice induction policy and documentation which was out of date.

Plan, agree and record meetings with the Patient Participation Group (PPG) to formalise arrangements and communication around practice specific concerns, issues or suggestions.

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 as there are areas where it should make improvements.

Arrangements for reporting incidents were in place with evidence of significant events and complaint investigations being completed. The outcomes of investigations were shared with staff members during daily verbal meetings. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses; however complaints were not always recorded, documented or discussed. There was little documented evidence of meetings, discussions, action points, reviews, and learning.

The practice manager we spoke with told us they supported staff and provided training, and that staff attended meetings where they were provided with information and were able to share learning and make suggestions; however none of these meetings were conducted in a formal setting.

Routine systems for dealing with practice alerts and fires safety drills, for example, were not recorded or evidenced.

Safeguarding policies and procedures were in place but not all of the non-clinical staff had completed safeguarding training to a satisfactory level. All clinical staff within the practice were adequately trained and skilled in Safeguarding adults and children. The lead GP responsible for child protection was appropriately trained at level 3. Staff knew the processes to follow if they wanted to raise any issues or concerns and would speak to the practice manager or the lead GP if concerned.

The practice was clean and well maintained with a cleaning schedule in place with up to date records. All staff had completed infection control training. There was evidence of effective infection control procedures being employed. The practice staff were supported by appropriate infection control and cleanliness policy and procedures, and were subject to regular auditing which was conducted by a representative of the local Clinical Commissioning Group (CCG).

Recruitment records and pre-employment checks had been completed before staff began work at the practice. Staff had received training in basic life support skills and the use of

Summary of findings

emergency equipment. Emergency drugs were in place to deal with medical emergencies by appropriately skilled and trained staff. There was an automated external defibrillator (AED) on site should it be required. Staff were able to alert each other in confidence in the event of an emergency or an unexpected event occurring.

The practice had systems in place for the management of medicines which were sufficient, and records were up to date and complete.

Are services effective?
The practice is rated as requires improvement for providing effective services and improvements should be made. The GP kept up to date with best practice standards and guidelines such as the National Institute for Health and Care Excellence (NICE) to ensure care and treatment was appropriate and effective.

Information sharing with staff was conducted in an informal manner verbally by the lead GP and manager within the practice and during staff and team meetings. There was no documented evidence however of meetings, discussions or outcomes to support the learning of staff and continual best practice within the practice.

The GP attended and contributed to monthly multi-disciplinary meetings within the community to discuss clinical topics, care and treatment, high risk patients and A&E attendance rates. There were also good links within the community for onward referrals to other health care agencies or treatment centres.

Clinical audits had been completed by the lead GP to support and manage care delivery within the practice. Audit topics included Atrial fibrillation (a condition affecting the rhythm of a person's heart) and osteoporosis (a condition affecting a person's bones).

There were appropriate systems in place to manage health reviews for patients with long term conditions.

Staff had access to the training they required and were guided locally by the practice manager in Health & Safety at Work, confidentiality and complaints. However not all staff had received or completed formal training required for their roles.

Are services caring?
The practice is rated as good for providing caring services. The practice had dedicated and skilled staff in place, who were patient focused, caring and approachable. Patients we spoke with told us that they were very happy with the practice, its staff and the

surgery's opening times. Care Quality Commission (CQC) comment cards received from patients at the time of the inspection highlighted that the care provided was exceptional. The lead GP also provided services to its patients working closely with other agencies such as district nursing, health workers, and palliative care nurses. We observed good patient and staff interactions. Patients were actively encouraged to be involved in their care and treatment by being offered a range of services and treatment appropriate to their needs. Systems were in place to seek consent before treatment was provided and the doctors and clinical staff were aware of the legal requirements for patients who did not have capacity to consent. We were able to witness exceptional behaviour of the receptionist on duty when dealing with an emergency patient who attended the practice. The patients was given the time and support they needed to be reasoned with during their crisis and an appointment was arranged with the GP immediately.

The waiting area was small and it was easy to overhear other people speaking. There was no dedicated space to speak to reception staff in private although the staff did tell us that they would provide a private space within the reception if required. The practice manager and all reception staff had completed training to provide chaperone services at the request of patients. Information about the chaperone service was provided in the waiting area. The practice was providing the services of a female GP every Tuesday for both morning and afternoon sessions. Language services and interpreters were contactable by practice staff as required.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice was responsive to patients needs as they had identified the health requirements of the registered patient population. The practice provided a range of services, clinics and appointment times to meet patient's needs. The practice offered and had access to both local and direct enhanced services. The practice had good facilities, space and equipment to treat patients and meet their needs. The practice had a complaints system and patients' complaints were responded to quickly. There was an active Patient Participation Group (PPG). Four members of the PPG came into the practice on the day of our inspection to discuss access to services, care and treatment on offer and how they felt they were treated by the practice staff and GP. The PPG members all commented that they had good relations with the practice and its staff and that they felt they were treated with kindness and respect and were provided with excellent care. Patients are involved in their care and treatment, through having choices for referrals through choose and book services, for patients own choice of hospital or specialist. Patients

were predominantly written to in English and we saw one example where the patient was written in Gulati. Other languages were spoken within the practice including Arabic, Hindi and Punjabi. Patients requiring repeat prescriptions could request these in person, in writing and on line. The practice was also able to issue some prescriptions to a local pharmacist for collection rather than requiring patients to attend the practice. All prescriptions and repeat prescription request were checked and validated by the lead GP before being authorised.

Are services well-led?

The practice is rated as good for being well-led. There were clear lines of responsibility and authority and the practice was well led by the lead GP. Although there was no formal vision document for the practice the lead GP told us they were very positive about the practice activity and was keen to develop plans in the future. The practice approach was to promote good health and wellbeing in a positive manner and at all times by being responsive to patient's needs, and was very positive that this approach to patient care was maintained at all times. Audits and risk assessments had been conducted as required detailing findings and outcomes and any learning and sharing of information was included within the audits. Staff were provided with annual appraisals on their performance which were documented and on-going. There was evidently clear structure and organisation within the practice, with the lead GP being responsible for safeguarding, infection control and complaints. Staff were very clear as to their roles and responsibilities. Staff did receive an induction from the practice manager with documentation which was kept alongside a practice procedures and policy manual which staff had access to. However, although the procedures and general information was kept in one place for staff to access and was on view, it was confusing and not easy to follow. Patients were positive about the practice and spoke highly of the GP and the practice team and about the care and treatment they received.

There was an active Patient Participation Group (PPG) at the location. The GP and PPG members were very positive and keen to engage, and discuss and develop services. There was also a comprehensive complaints procedure and process in place. We were unable to see any minutes of meetings with the PPG and it was unclear how often meetings took place. The PPG representatives we spoke with told us that there were good relationships with the lead GP and the practice staff and that there was no evidence to suggest more female GP cover was required.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. The practice had a system in place to ensure that all patients over the age of 75 years had a named GP. This ensured continuity of care and the treatment being provided. The practice had also begun to further support this population group by compiling and detailing integrated care plans for identified patients within the practice population, involving the patient holistically in the care and treatment plan, and recording additional information in the plan by including a patient questionnaire. All staff within the practice had received end of life support training in December 2013. Bereavement support was available and provided by the lead GP and nurse with the support of an area counsellor. The lead GP and nurse were also providing locally enhanced services to dementia diagnosed patients and were able to refer to other services if appropriate. The practice GP was monitoring closely patients who required palliative care by reviewing this patient group on a monthly basis, with input from other care providers involved with the patients' care plan to ensure care plans, treatment and medication requirements were up to date and responsive to patients' needs. Treatment and care extended into annual reviews of all patients over 75 years of age ensuring assessments for memory loss were completed and that End of life care was also pre planned with patients and their relatives. Improvements for this patient group could be enhanced by completing all formal training requirements for staff related to safeguarding adults and vulnerable patients.

People with long-term conditions

The practice is rated as good for the care of people with long-term conditions. The practice GP was able to complete home visits at request and take telephone consultations as required when patients wanted advice or were unable to attend the practice. All patients identified with long term conditions or medications requirements such as diabetes, asthma and hypertension for example, were subject to six monthly reviews of care plans which were flagged on the practice systems prior to patients being contacted and asked to make an appointment. The CCG pharmacists for the local area would be invited to attend the monthly clinical team meetings if relevant to the topics on discussion. The practice also offered on line repeat prescriptions.

The practice GP was monitoring closely patients who required palliative care by reviewing this patient group on a monthly basis,

with input from other care providers involved with the patient's care plan to ensure care plans, treatment and medication requirements were up to date and responsive to their needs. Patients with long term conditions not seen for an extended period of time would be contacted by the practice to check health status and offer appointments, the practice manager told us that they reach out to patients well for all health checks. The practice used a risk stratification tool to monitor patients with high risk scores of hospital admissions and long term conditions and frequent users of emergency services. Patients with two or more long term conditions, including mental health problems, were subject to higher levels of health monitoring to ensure their well being.

Mothers, babies, children and young people

The practice is rated as good for the care of families, children and young people. It had an open access policy on appointments for all patients who required urgent or emergency care or treatment. The lead GP also informed us that all mothers and children would be seen within the practice in addition to routine appointments in times of urgency. The practice provided a number of clinics and appointments for health checks and child immunisations. This also included sexual health screening and referrals services for young people. Other clinics within the practice included family planning, mother and infant checks and contraceptive pill checks. The provider offered a range of services to provide care and treatment to families, children and young people, including ante-natal clinics, post natal clinics for mothers and babies six week check, Measles, Mumps and Rubella (MMR) for patients aged 16 and over and chlamydia screening for example. Nurses were available to provide immunisation and vaccines advice and treatment. Patients in this population group were of a diverse background and culture with various social, cultural and health needs. The provider catered for all patients supporting them to seek primary care at all times.

The working-age population and those recently retired

The practice is rated as good for the care of working age patients and those recently retired and students). The practice had provided additional telephone lines recently and patients could make online appointment bookings. The practice provided extended hours appointments in the evening until 7.30pm every Monday, Tuesday and Friday. The GP told us it was sometimes possible for additional phone consultations to be provided, with additional emergency appointments being given as required. Nurse led health checks and reviews were available to both men and women with reviews being provided within three to six months in agreement with the patient. Blood pressure checking and monitoring services, medication

advice and patient support and advice such as life style health information was being provided and promoted. The practice was also offering nutritional therapy, menopause clinics, diabetes management and insulin initiation and travel immunisations. There was a practice leaflet available on request from the reception staff which although detailed would benefit from being brought up to date with correct patient and practice related information, and should be made readily available within the patient waiting area. The practice offered smoking cessation clinics.

People in vulnerable circumstances who may have poor access to primary care

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice employed a temporary patients scheme for relatives or visitors of those patients who were already registered. The lead GP advised that he would see vulnerable and unregistered patients through the same process if they attended and required urgent medical care and attention or referral. The lead GP also told us that people who were homeless or in need of urgent or emergency care and treatment would be seen within the practice or referred appropriately and safely into local patient services. The practice also provided health checks for patients aged 18 and over with learning disabilities.

People experiencing poor mental health

The practice is rated as good for the care of people experience poor mental health. The practice was providing adequate caring services to patients in this patient group and had good local arrangements in place to provide caring services to people experiencing poor mental health. Referrals could be made by either the lead GP or nurse to appropriate services within the local area such as the Pembroke Centre and Mill House for mental health assessments and management. The doctor was aware of the legal responsibilities regarding consent and patients capacity to make decisions. The practice and lead GP also ensured that patients received medication reviews and care plan reviews every six months or earlier at either the request of the patient or the practice.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection and received 33 Care Quality Commission (CQC) comment cards completed by patients who attended the practice during the two weeks prior to our inspection. The nine patients we spoke with said that they were very happy with the care and treatment they received. They were very complimentary about the caring and approachable staff and had no complaints about the practice staff or care provided. Twenty eight of the 33 comment cards received indicated that patients were happy with the GP and the care and treatment afforded to them. Patients also told us that staff were caring, friendly and polite, that they were treated with respect and dignity, and that staff were informative and listened to their concerns or worries. Patients also informed us that they were given options and were included in any treatment plans or recommendations. All 33 comment cards seen indicated satisfaction with the GP, the practice and its staff, and all gave praise to the professional and dedicated caring service and responses to patient needs. Five of the 33 comment cards received made reference to the small size of the waiting area, and that at times it was difficult to get an appointment, and that the waiting area can get busy, feel crowded and noisy.

Comments made in the GP patient survey 2013 and NHS choices website showed the report compared less favourably with other practices in the area in some areas. For example, only 54.6% would recommend the practice. Only 68.8% rated the practice positively for opening times and 61.9% for their experience of making an appointment.

The practice did not have any place for patients to make comments or suggestions within the practice.

Areas for improvement

Action the service MUST take to improve

- Take action to ensure that at all times, there are sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying out the regulated activity.
- Implement formal procedures for recording and documenting records of all staff meetings and minutes to safeguard internal practice and information challenges.

Action the service SHOULD take to improve

- Ensure that the practice leaflet is up to date with information on what to do when the practice is closed.
- Make the patient leaflet available within the waiting area of the practice.
- Update the practice induction policy and documentation which was out of date.

Plan and agree meetings with the Patient Participation Group (PPG) to evidence communication around practice specific concerns, issues or suggestions. Implement formal procedures for recording and documenting these meetings to safeguard internal practice systems and processes, and information challenges

Dr Muhammad Misbah-Ur-Rehman Siddiqui

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a Care Quality Commission (CQC) Lead Inspector who was accompanied by a second CQC Inspector, an expert by experience, and two specialist advisors. One specialist advisor was a GP and the other was a practice manager.

Background to Dr Muhammad Misbah-Ur-Rehman Siddiqui

Dr Muhammad Misbah-Ur-Siddiqui, also known as The Walnut Way Surgery, provides GP services from a two storey converted house within the suburban area of Ruislip. Access to the practice is suitable for people with mobility issues, although entry to the practice nurse consultation room on the first floor may be difficult for the disabled, frail, pregnant mothers and those with small children.

The practice provides general practice services to over 3,300 patients from within the local area of Ruislip and Hillingdon. Hillingdon is the 130th most deprived out of 326 local authorities. In Hillingdon there are high levels of deprivation, and child poverty, recorded diabetes, new cases of tuberculosis, acute sexually transmitted infections, statutory homelessness and violent crime are significantly worse than the national average. Hillingdon has an increasing population and a higher than average proportion of Black and Minority Ethnic residents. Life expectancy is 6.6 years lower for men and 4.7 years lower for women in the most deprived areas of Hillingdon than in the least deprived areas. With the exception of English, Punjabi is the most common language spoke in the borough followed by Polish, Tamil and Urdu.

Information and area intelligence indicate increasing numbers of diabetic patients, cardio vascular disease (CVD), and patients over 65 years of age and over with a limiting long term illness, patients and their condition management is a focal point for all local primary care services within the local Clinical Commissioning Group (CCG) area.

The practice is one of 48 GP practices located within the Hillingdon Clinical Commissioning Group (CCG). The CCG and the NHS England local area team are responsible for commissioning care and services to a diverse population of over 273,936 within the borough of Hillingdon. These include hospital, community and mental health services.

The Dr Muhammad Misbah-Ur-Siddiqui practice patient list is varied in age from young babies, children, and adults, the majority of which are adults. The practice provides approximately 280 patient appointments per week, with additional urgent and emergency appointments as required.

There are eight qualified and suitable staff working within the practice offering various services in patient care and treatment, management of disease, disorder or injury. There is one male full time GP and one female locum GP, one practice manager and one female nurse. There are four reception/administration staff. The practice is not a training practice and is contracted for General Medical Services.

Detailed findings

The practice has opted out of providing out-of-hours services. The arrangements for out-of-hours services are accessible through the NHS 111 system, which the provider communicated to patients in surgery posters and website information. However at the time of inspection this information referred to NHS direct and was out of date.

Why we carried out this inspection

We inspected this service under section 60 of the Health and Social Care Act 2008 and as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them. We also determined which services to inspect through intelligence monitoring, public perception and engagement and partnership working with the local Care Commissioning Group (CCG), and to pilot new inspection methodology under Primary Medical Services wave 2 guidance.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England, the Clinical Commissioning Group and Healthwatch to share information about the service. We carried out an announced visit on 27 August 2014. During our visit we spoke with a range of staff which included the lead GP, nurse, practice manager, receptionist and administration support staff. We spoke with a nine patients who used the service and to four members of the Patient Participation Group (PPG). We observed how people were being cared for and looked at records including recruitment, health and safety checks, staff training, medicines management, equipment checks, audits, complaints and significant events, and policy and procedure documents. We reviewed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

We reviewed a total of 33 comment cards collected as part of our visit. The overarching view was that patients trusted the practice staff and GPs; the care on offer was exceptional and tailored to their individual needs; patients felt confident in the care and treatment on offer; and they were continuously treated with kindness in a caring manner and were always treated with respect and dignity.

Are services safe?

Our findings

Safe track record

There were systems in place to provide safe care. The lead GP was responsible for receiving safety alerts, patient notifications, and discharge summaries. Safety alerts and notifications were discussed as required and informally at daily team meetings. These discussions were not documented however.

There were arrangements in place for the recording and reporting of incidents, however in the absence of a formal documentation process or written evidence it was unclear how any learning or sharing of information was disseminated other than being discussed at monthly team meetings. These meetings were documented and we saw the minutes. Staff we spoke with were clear about their role and responsibilities and knew how and when to report issues, concerns or incidents to the lead GP. They told us that they were able to contribute and make suggestions during team meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The lead GP kept records of significant events which showed that there had been two significant events during 2014 and three in 2013. The lead GP was able to offer explanation into this further by recommending and implementing change based on the individual record and feedback received. Significant events were taken seriously and acted on, and would be discussed with staff during daily team meetings as necessary and in confidence, and we were provided with examples of two recent events involving infection control and treatment, and the giving of an incorrect travel vaccine.

The primary GP was the lead for mental health within the practice and had good network working relations with mental health care teams to support patient care and outcomes; both the lead GP and nurse had responsibility and the ability to refer patients to appropriate services for mental health referrals and assessments.

Reliable safety systems and processes including safeguarding

The lead GP was the lead for safeguarding and was trained to level three in child protection. The practice nurse was awaiting the outcome of level two safeguarding training they had recently undertaken. Training records we saw confirmed that all non-clinical staff had either completed safeguarding training for both adults and children or were in the process of completing the required training. The practice manager had responsibility for ensuring best practice methods and processes were applied and managed accordingly and that staff were aware of their responsibilities to report concerns. Staff we spoke with were fully aware of the practice policy and their roles and responsibilities for reporting, recording and raising concerns or issues with the GP safeguarding lead.

The practice had a chaperone policy in place and there were notices informing patients of this service in the waiting area. Chaperone training provided by the practice manager had been undertaken by reception staff and was further supported by formal training having been completed through distance learning methods and systems, before staff could perform chaperone duties they were subject to the Disclosure and Baring Service (DBS) checks which had been completed or were in the process of being completed. Children's care and treatment was a priority for the practice and the GP told us that they would be offered urgent and emergency appointments and would always be seen by a GP.

Medicines management

Medicines were suitably stored and maintained. Repeat prescriptions could be requested at the practice and online with 48 hours' notice required. We saw records to demonstrate that the fridges where vaccinations and medicines were stored were checked daily. The checks were recorded to ensure that the fridge temperature was within the recommended range. Medications we inspected were all stored correctly, with use of fridges to maintain the cold chain for medications that required storing in this manner. There were no controlled drugs kept at the location. Medicines and emergency drugs were within date and unopened, secured safely and stored appropriately. Medication prescription pads were also secured safely and available to appropriately qualified staff within the practice.

Cleanliness and infection control

We found the location and premises to be clean and free from clutter. There was an infection control policy and procedure in place; Records we saw demonstrated that all staff had attended infection control training. We saw that a daily cleaning schedule was in place and we were able to

Are services safe?

view records of completed daily and weekly cleaning schedules. Clinical equipment and furniture was clean and well maintained. There were appropriate and suitable amounts of personal protection equipment (PPE) for example gloves, aprons and goggles, cleaning wipes and gels. There were no hand sanitizers located within the waiting area of the practice, however hand sanitizers and hand hygiene notices were in place within all the treatment rooms.

Equipment

Systems and procedures were in place to ensure staff had access to equipment they needed to provide care and treatment at the practice. Equipment was stored and secured safely with regular checks of equipment levels. Checks were completed to ensure equipment in use at the practice was in good working order. Arrangements were in place to ensure annual checks of portable electrical appliances and fire extinguishers were completed.

Staffing and recruitment

Staff were recruited in line with regulatory requirements and we saw evidence that the appropriate checks had been completed prior to staff beginning work. This included photographic identification, health checks, Disclosure and Baring Services (DBS) checks, references, and proof of identity and address. All staff had a training schedule in place which was accessed within the practice' online training system. The practice policy and procedure for recruitment was up to date and contained appropriate and relevant documentation to ensure people employed to work at the practice had been properly checked before starting work.

Monitoring safety and responding to risk

There were systems in place to monitor and respond to risk, including the flagging of risk registered patients, for example children who had increased attendance at accident and emergency departments. Newly pregnant mothers and children were seen urgently and in addition to appointment slots.

Staff had received some training from the practice manger in the recognition and management of vulnerable adults and children and knew what action to take and who to inform within the practice, although not all non-clinical staff had received formal training in this area.

The practice had no additional capacity to provide support to maintain service delivery during normal routine business operation or in the event of a crisis. There was no procedure in place for meeting additional demand or what actions would or were taken when staffing was reduced or when staff took annual leave.

There was also no adequate provision to cover roles and responsibilities other than the practice manager informing us that there was an awareness of busy periods and that providing support to reception and administration staff was usually sufficient. Any concerns raised were recorded and in line with data protection requirements and stored securely. The GP's within the practice and clinical staff could be alerted to any concerns though appropriate use of electronic messaging systems within the practice.

Arrangements to deal with emergencies and major incidents

The practice had equipment, medications and an automatic external defibrillator (AED) on site for use in medical emergencies. All practice staff were trained in its use and basic life support techniques. There was a panic alarm situated within the GP and Nurses Treatment rooms and reception area, staff knew what actions to take if the alarm sounded. Regular checks of the equipment were undertaken and documented. All practice staff had been trained in basic life support. There was no documented evidence in place for fire evacuation procedures, or what actions staff should take in the event of a fire. We were ensured by the practice manager and staff that there was a procedure for designated staff within the practice which would be implemented as needed, which staff were able to discuss with us and were clear and specific in relation to their role and required actions they needed to take in such an emergency. The practice did ensure a print out of appointments was completed daily and in advance of the next day's surgery, in case of computer appointment booking systems were not operational

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The lead GP kept up to date with best practice guidelines and had links to National Institute for Health and Clinical Excellence (NICE) guidance. The GP attended meetings and training arranged through the Clinical Commissioning Group (CCG) including for example, 'hot topic conversations' and work on referral pathways. The practice measured and compared its effectiveness by using the Quality of Outcomes Framework (QOF) indicators to compare their results using performance indicators, targets and referral rates. QOF is a national performance measurement tool. The practice was also comparing its services against other practices in the locality by undertaking audits, such as referrals to dermatology clinics, and patient outcomes. It monitored the number of patient complaints and compliments it received.

Patients had their needs assessed and care was planned The GP was able to provide examples of best interest decisions that the GP had been involved with, which included other health and care professionals to ensure the patient's needs and requirements were met.

Predominantly the lead GP and nurse were skilled in patient care including recognition of vulnerable adults, children, neglect and abuse. Staff reassured us that they would raise concern for any patient who they had concerns about. This was important for all patient types, but especially mothers, babies and children, and patients over 75 years of age. We were provided with evidence of effective needs assessment being conducted by the lead GP to identify changes in behaviour and health concerns that were then highlighted to appropriate clinical staff by the use of a dementia and change in behaviour questionnaire for patients aged 40 to 74 years of age. The practice would then use this information to provide patient care and support as needed. There was a named GP and care register for all patients over 75 years of age, and for patients with learning difficulties. Consent was always sought from the patient, and chaperone and advocacy services were available. The involvement of a chaperone was recorded to safeguard all parties.

The service was also effective in providing baby immunisations, following up on any patients that did not attend appointments. There were systems in place for patients who were housebound and unable to attend the practice to be monitored and contacted. The practice promoted and assisted in care planning and treatment by joint working with district nursing, tissue viability nurses and the nursing home whose patients were registered with the practice. Unplanned admissions and use of enhanced services were subject to regular reviews as were medications usage and prescribing for all patients aged 75 and above.

Management, monitoring and improving outcomes for people

The GP was clear about the relationship between the Quality and Outcomes Framework (QOF) and measuring the practice's performance. The practice participated in clinical audits to drive service improvement and promote best care and treatment. We saw examples of audits that had been completed in atrial fibrillation, osteoporosis, dermatology, and a statins audit and review. There was an ongoing cycle of auditing smear tests twice annually, and any smear results which were inadequate were discussed with the lead GP and repeated as necessary. Monthly team meetings were held with staff to ensure best practice was delivered and were used as a forum for staff to raise concerns or issues. The results of audits and re auditing completion cycles were used to improve care for patients and to improve the learning within the practice team.

Effective staffing

The practice employed a small team which consisted of a lead GP, a practice nurse, a practice manager, two reception staff and two administration and support staff. A female GP was employed weekly on a Tuesday. There was no documented policy or procedure of contingency resilience planning in effect to address planned and unplanned absences. Patient participation group (PPG) representatives we spoke with raised concerns about only having one practice nurse and told us that this had been raised with the practice. The GP informed us that the practice was in the process of trying to recruit an additional nurse. Staff we spoke with told us they were encouraged to contribute to team meetings and during their annual appraisal. The GP was responsible for all staff annual appraisals which had been completed in May and June 2014 or were due for completion. The lead GP was not due for revalidation until 2016.

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The lead GP and nurse was working with colleagues and other services to provide care and treatment to patients including district nursing, health care workers and palliative care nurses. The lead GP also attended monthly multi-disciplinary meetings to review and discuss patient cases such as complex care cases, children on the at risk register and elderly patients for example. The lead GP was the direct link with the local CCG, other local health care providers, and a local nursing home. The practice nurse was also able to make patient referrals, such as mental health assessments, subject to checking and validating decision making with the lead GP. Patients requiring blood tests were normally referred to a local centre that was providing this service, with the results sent back to the practice within two to five days. The practice had the ability to take blood samples if required for some patients. The service received test results and discharge summaries which were all reviewed and actioned for any changes required to care and treatment plans or medications.

The lead GP was engaged with multi-disciplinary team meetings and met on a monthly basis to discuss care plans, and care and treatment for patients within different population groups. The primary GP was the lead for mental health within the practice and had good networking relations with mental health care teams. Both the lead GP and nurse had responsibility and the ability to refer patients to appropriate services.

Information sharing

The practice held monthly team meetings for staff to share information and learn from experiences, including areas of concern, issues or complaints. The meetings were also used as a forum to alert staff to any concerns or issues related to the practice, patient care and treatment, and updates to processes or policy changes. The meetings were not formally recorded and documented for evidence and future reference.

Patients in the waiting area were provided with information in the form of posters and patient information leaflets such as repeat prescriptions, test results, surgery hours and carers support, There was also an information screen for sharing information visually with patients.

The systems used for patient records and information were subject to data protection and information governance control with a practice policy and procedure to support the staff in the correct use of patient data.

Consent to care and treatment

Patients told us that they were always asked for consent before care or treatment was provided. The GP advised us that consent would be sought from the parent or legal guardian of young children and was aware of their legal responsibility in relation to a patient's capacity to understand and receive care or treatment. There was good knowledge and understanding of the Mental Capacity Act (MCA), and of other competencies such as Gillick. Staff knew how and when to use assessment tools to aid patients and support decision making. Written consent was provided and recorded for all treatments that were available within the practice. There were suitably skilled and qualified staff in place to ensure understanding, and competencies were considered, measured and applied correctly to respond to patients in all population groups.

Health promotion and prevention

Health promotion and prevention services included nurse led smoking cessation clinics, diabetes clinics, and nutritional advice for example. Patients could keep up to date with health information from the posters and information leaflets contained within the waiting area on topics such as bereavement support, female genital mutilation (FGM), Hillingdon carers support group, NHS complaints and advocacy, stop smoking advice and helplines such as the National Society for the Prevention of Cruelty to Children (NSPCC). The practice website also had good information and advice to promote healthy choices and access to a range of services.

All new patients were offered patient health checks which ensured that care and treatment was tailored to their individual needs and requirements. The practice nurse also provided health checks to patients between the ages of 40 – 74 years. Patients were offered advice and follow up appointments following the health check with agreed time scales of three to six months.

Systems were effectively used to support chronic disease management by ensuring regular reviews and patient follow ups.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients we spoke with on the day of our inspection visit told us that they were very happy with the GP and the practice. Patients said they were treated with respect and courtesy, were informed and involved in their care plans and treatment and that they were helped to understand the care choices available to them. Twenty eight of the 33 Care Quality Commission (CQC) comment cards we received indicated that patients were happy with the services on offer and the staff within the practice. Comments conveyed high praise to the GP and practice staff, commending them on their professionalism and conduct. Patients also indicated that getting an emergency appointment was usually accommodated and that waiting times were reasonable. Some patients commented that the waiting area was small and sometimes noisy and busy. We were able to observe staff interactions and saw that all were conducted in a respectful and courteous manner. We observed all staff within the practice treat patients with dignity and respect at all times. There was an atmosphere of community care and spirit throughout the practice with compassionate professionals responding appropriately to care and treatment requests.

Care planning and involvement in decisions about care and treatment

The lead GP and practice nurse understood the relationship between information sharing and making best interest decisions and were able to provide us with examples during our interviews. One example was that of a patient who was able to be cared for without referral into child services by working closely with the patient's family and having the ability and provision to care and support the patient from within the practice by competent and skilled qualified staff. Patients we spoke with on the day had no concerns over involvement in their treatment. All patients said that they were involved in the decision making process and that all the options for treatment were explained to them. They also told us they felt listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

Patients indicated that they were supported physically and emotionally and were able to speak in confidence with the GP, nurse and practice staff. The GP was able to provide examples of best practice and had good relationships with referral agencies and other health and social care providers and agencies such as bereavement counselling. The GP looked after patients resident at a local nursing home in partnership with district nurses and tissue viability nurses based in local health centres. The GP also worked with other health professionals to provide care for housebound patients and those with end of life care needs. The lead GP conducted home visits to patients as required. Patients over 75 years of age or with long term conditions were able to contact the doctor directly or by request for immediate concerns, advice or support. Mothers and babies were also supported by the lead GP and practice staff. This supporting system and management included identifying and reviewing patients that required vaccinations or immunisations for example, and then contacting them to offer appointment or to check if they had any health concerns.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

In addition to the normal GP arrangements within the practice there was also the option for patients to see a female GP that worked weekly on a Tuesday. Within the waiting area there was an electronic information screen for the purpose of sharing patient information such as opening times and how to get test results for example. Information was provided for patients whose first language was not English and included how to access the practice's services. Reception staff could access language assistance services by telephone or online. Information leaflets for patients were predominantly written in English. Some limited information was available in other languages also. The GP spoke four languages. The practice had a hearing loop for hard of hearing patients.

The GP attended integrated monthly care meetings to discuss and review individual care plans, such as those for patients with high risk scores, long term conditions, and palliative care needs. Other topics of discussion included reducing avoidable attendance at A&E departments. The practice offered a variety of clinical services to patients which included diabetes management, post-natal care for mothers, six week baby check, MMR for patients aged over 16 years , hepatitis C vaccination for university students, smoking cessation support and health checks for patients with learning disability. The lead GP offered home visits and longer appointments as required if patients were unable to attend the practice or required more time with the GP. They also offered telephone consultations to improve access to care as required and on request. The practice offered extended hours and evening surgeries to further meet people's needs.

The practice had a newly formed Patient Participation Group (PPG) that had only met once with the practice prior to our inspection visit. There was no written record of the meeting and it was unclear how often the PPG would meet in future. The PPG was very positive about the care and treatment available through the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example for those patients with "no fixed abode", temporary registration with the practice was offered and the practice address was used for any letters regarding treatment. The practice had access to a telephone translation system which could be accessed for consultations. The practice was able to provide limited written literature in alternate languages to English. Staff at the practice spoke a variety of languages including Arabic and Hindi. Patients whose first language was not English could request interpreting services at the practice reception and this was highlighted to patients in the form of a poster within the waiting area.

The practice was mainly situated on the ground floor of a converted house. The nurse's room was situated on the first floor. Patients unable to access the first floor by the steps would be seen within the ground floor consultation room as required. The ground floor disabled toilet was also of concern regarding access and ease and usage of the facilities being provided; meaning that patients may not be able to reach the hand basin, soap or towels comfortably.

The practice actively supported people who had been on long term sick leave to return to work by the use of the 'fit note' and phased return to work.

Access to the service

Appointments could be made in person, by telephone and online booking. There was also the facility to request repeat prescriptions online though the practice website. There was an information screen within the waiting area. The practice information leaflet was a very clear and useful document, however some of the information who to contact outside of surgery times or in an emergency or when requiring help or advice was out of date. The Practice had sub contracted to Care UK to provide services outside of surgery hours and was also supported by NHS 111 services for its out-of-hours service provision. This information about out-of-hours services was not reflected in the practice leaflet. The practice leaflet was available on request from reception and there was no supply of practice leaflets in the reception area.

The GP described how work with the Practice Participation Group (PPG) had identified a need for an additional telephone line to provide better access to the service, which had been implemented. Access to the GP services was by appointments only four and a half days a week not including weekends. The provider also provided emergency appointments on request and as required, and extended hours and evening surgeries to improve access for all population groups. Telephone access to the GP also

Are services responsive to people's needs?

(for example, to feedback?)

allowed additional consultations to be offered where needed, sometimes outside surgery appointment times. The GP provided direct care services to all patients over 75 years of age and patients diagnosed with cancer.

Listening and learning from concerns and complaints

There was a complaints procedure and process in place which made reference to other services that could be accessed if a complaint was unresolved by the practice, including the Patient Advice and Liaison Service (PALS) and the Parliamentary Health Service Ombudsman (PHSO). The practice manager had responsibility for complaints and the procedure, which had been reviewed in April 2014. The practice waiting area contained poster information on complaints and the complaints procedure itself was readily available from reception staff. We saw records of the complaints received by the practice during the past 12 months: there were two in total. Complaints were resolved locally with the lead GP or practice manager, and any learning from complaints was discussed with staff during monthly team meetings. The practice had completed four team meetings since May 2014 and we were able to see minutes of the meetings.

Are services well-led?

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

Our findings

Vision and strategy

The practice belief and its staff values were to be patient focused at all times. We observed a caring and responsive environment and leadership by the lead GP. There were no documented vision statement or practice wide objectives in place, however, or documented plan for the future of service delivery. The GP did have a practice vision and told us that he would like to have bigger premises and promote a health centre, and that they wanted to become a teaching practice, employing more staff and providing more services. Patient's comments seen from the national patient's survey 2012 to 2013 indicated improvements could be required however the practice atmosphere and patient interactions were all positive and reassuring which reflected the culture and mind set of all staff employed within the practice. This was supported by the positive and compassionate comments received from patients during our inspection and those received within patient comment cards. Patients comments were also seen from the national patient survey

Governance arrangements

The lead GP was the focal point for governance and decision making at the practice and was extremely keen and positive in discussions about patient engagement and collaborative working with other health care services and providers. Staff were motivated and appeared supported and happy in their roles. The nurse within the practice was suitably skilled and qualified and comfortable with their responsibilities, and had the support and ability to verify and validate care and treatment decisions for patients with the lead GP. The practice manager was able to evidence that training in information governance had been completed. They were responsible for the management of policies and procedures affecting the practice, for the staff employed there, and for disseminating information to staff.

Leadership, openness and transparency

The lead GP had an open door policy and both his staff and services were available on request and dependent on immediate needs. The GP was completing audits as expected for professional development and to improve services. Staff were afforded annual appraisals and on-going training which was mainly distance learning. The GP was aware of the practice performance data available in the wider NHS and offered solutions as to why this could be improved; concluding that they were trying to improve outcomes and quality data scores. The lead GP was aware of areas for improvement and that they could improve over time with support and continuous engagement with the practice, the Clinical Commissioning Group (CCG) and local NHS services.

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

The practice had a Patient Participation Group which had been operating for one year. We met with four members of the PPG who indicated that they were very happy with the lead GP, the practice and its staff, services and care and treatment on offer. Also, as a result of collaborative working they had already seen improvements and changes being made to provide a better service as a result of direct engagement with patients. The provision of an additional telephone line into the practice was a recent improvement made to the practice to improve access.

The lead GP told us that the Chlamydia and Gonorrhoea screening programme had a low uptake, and that he was aware of this but suggested that as a community run practice younger people seemed not to want to engage locally and were seen elsewhere within the area.

The practice manager told us that the practice were in the process of completing a patient survey for 2014; and that the Practice Participation Group (PPG) had only been in place for one year.

Management lead through learning and improvement

Staff were able to attend monthly meetings to raise concerns or issues and told us they were able to speak to the practice manager or GP openly and honestly at all times. They also told us that there was an induction policy and that they were all supervised during their induction. Staff were provided with an annual appraisal and their skills and knowledge were tested during monthly team meetings and at appraisals, which were documented and evidenced as minutes for meetings. Staff felt listened to and felt they were able to contribute to the wellbeing of the practice. We were unable to see any documented evidence for daily staff meetings, minutes and action plans, and any practice wide learning that could have been shared through this process. The practice manager and lead GP were the focus point for staff learning which was provided

Are services well-led?

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

informally in relation to systems usage, Health & Safety, and complaints for example. Information governance and confidentiality training had been completed by the practice manager.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying out the regulated activity. Regulation 22.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of records. Regulation 20 (1) (b), (i), (ii). (2), (a), (b), (c).