Dr Muhammad Shahzad

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Dr Muhammad Shazad (also known as Zain Medical Centre) on 4 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services to the six population groups we inspect - People whose circumstances may make them vulnerable; Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); and People experiencing poor mental health (including dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles, with the exception of chaperone training for non-clinical staff.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients (via a survey), which it acted on.

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

Importantly the provider should:

- Ensure staff who act as chaperones have received appropriate training.
- Establish a patient participation group.

Summary of findings

- Ensure staff are familiar with the practice's vision and values.
- Ensure staff are aware of the whistleblowing policy.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed, however non-clinical staff who chaperoned had not received training and one staff member was unfamiliar with their responsibilities in this regard. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed most patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of completed clinical audit cycles to improve patient outcomes. However, last year's performance was below national averages for the majority of immunisations where comparative data was available. Staff had received training appropriate to their roles and also received annual appraisals. Staff worked with multidisciplinary teams and regular meetings were held.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The National Patient Survey 2014 indicated patients rated the practice above the CCG average for the GP and nurse explaining care and treatment and the helpfulness of the receptionists. However it fell below the CCG averages in, for example, the GP giving the patients enough time, and for confidence in the GP.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The needs of the practice population were understood and systems

Summary of findings

were in place to address identified needs in the way services were delivered. For example, a female GP provided consultations one day a week to cater for those patients who preferred not to see a male GP. Patients said they found it easy to make an appointment. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. For example, as a result of patient complaints about the difficulty in getting through on the phone in the mornings, an additional receptionist was added to answer phones.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy however these had not been formalised and some staff were not familiar with them. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on although the practice did not have a patient participation group. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was a whistleblowing policy in place but not all staff were aware of it.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that most outcomes for patients were in keeping with the locality average for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP. The practice made use of the STARR team (short-term assessment, rehabilitation and re-ablement service), an initiative funded by the local CCG to help support its elderly patients.

Clinical and non-clinical staff had received carer awareness training to help them identify the needs of carers looking after elderly patients, so they could offer additional support where appropriate.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions (LTCs). Longer appointments and home visits were available when needed. All these patients had a named GP and an annual review to check that their health and medication needs were being met.

The practice was part of the Harrow integrated care planning pilot and met monthly with a care co-ordinator to assess the needs of patients with LTCs. Patients could book to attend review clinics for chronic conditions such as asthma and diabetes, and the nurses assisted the GPs with these reviews. Patients could request repeat prescriptions online and these could be sent to a pharmacy of the patients choice, provided it supported electronic prescribing.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided ante and post natal care; contraceptive advice and provided sexual health advice for young people. The practice's performance for childhood immunisations was below the national averages where comparative data was available. Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

The practice's computer system would flag up if there were any safeguarding concerns and such patients were prioritised for appointments if they requested one. If none were available then the GP or nurse would telephone.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Extended hours were available for appointments on Friday evenings from 18:30 to 19:30. NHS health checks were offered to patients aged 40 to 75. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including carers and patients with a learning disability. Patients with a learning disability were offered annual health checks and longer appointments. Staff were aware of carers' needs and signposted patients to support services.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Longer appointments were made available and staff involved these patients in the planning of their care. Staff sent text reminders to patients experiencing poor mental health to assist them to keep appointments. The practice provided patients with information about how to access emotional support services.

Summary of findings

What people who use the service say

We received 43 CQC comment cards. All of these were positive with regard to the service provided; the attitude of the GP and other staff and the cleanliness of the premises. One patient commented that it was sometimes difficult to get an appointment quickly however no other concerns were expressed.

The National Patient Survey 2014 indicated patients rated the practice above the CCG average for the GP and nurse explaining care and treatment and the helpfulness of the receptionists. It was also above the CCG average for the ease of getting through by phone and the convenience of the appointment. However it fell below the CCG averages in, for example, the GP giving the patients enough time, and for confidence in the GP.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff who act as chaperones have received appropriate training.
- Establish a patient participation group
- Ensure staff are familiar with the practice's vision and values.
- Ensure staff are aware of the whistleblowing policy.

Dr Muhammad Shahzad

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 who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Dr Muhammad Shahzad

Dr Mohammad Shazad, also known as Zain Medical Centre, is situated in Edgware Middlesex, and is one of 35 practices within Harrow Clinical Commissioning Group (CCG). The practice has a General Medical Services (GMS) contract for providing general practice services to the local population, and it also provides a number of Directed Enhanced Services (DES) such as Rotavirus and Shingles Immunisation and Extended Hours Access. The patient list size is approximately 2,100.

The practice is open every weekday morning from 08:30 and closes at 18:30 on Monday, Tuesday, and Thursday; at 14:00 on Wednesday afternoon; and 19:30 on Friday evening. Appointments are from 09:00 to 12:00 every morning; and from 16:30 to 18:30 on Monday, Tuesday, and Thursday afternoon; and 16:30 to 19:30 on Friday. Appointments must be booked in advance over the telephone, online or in person. Extended hours surgeries are offered from 18:30 to 19:30 on Friday evening. The practice has opted out of providing out-of-hours services to their own patients. Patients are advised to call an out of hours telephone number. The practice website also refers patients to the NHS Direct helpline however this service ceased operation in March 2014.

Dr Shazad is registered with the Care Quality Commission to carry on the regulated activities of Maternity and midwifery services, Diagnostic and screening procedures, Surgical procedures, and Treatment of disease, disorder or injury. This is the only location operated by this provider.

The staff team at the practice were one male GP, a female practice manager, two female nurses and three female receptionists. Dr Shazad is an approved training practice and will at times have medical students in attendance. Once a week, on Wednesdays, a female GP attends the practice to provide consultations for those patients who prefer a female doctor.

Cardiovascular disease (CVD) is the main cause of death in Harrow, both the rate of new cases and rate of death are lower than for England and London and are decreasing. It is the main cause of the gap in life expectancy in both men and women in Harrow. Diabetes, which is closely linked to cardiovascular disease, is more common in Harrow than in England as a whole due mainly to the higher prevalence in South Asian communities. It is generally well managed. Although there have been very small increases in diabetic coma and amputations in recent years, the rates for all diabetes complications are still amongst the lowest in England.

More than half of Harrow's population is from black and minority ethnic groups, making Harrow one of the most ethnically diverse boroughs in the country. The largest group, after white, is Indian. The practice has a deprivation score of 18.6, compared to the national average of 23.6.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a

Detailed findings

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. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 February 2015. During our visit we spoke with a range of staff including the GP principal, the practice manager, a practice nurse and two administrative staff, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The last recorded incident had been in November 2013. Staff were aware how to report incidents and told us these were shared with staff informally and also during practice meetings. National patient safety alerts were disseminated by email to practice staff.

The practice reviewed incidents annually. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example we reviewed the record of the November 2013 incident which related to an aggressive patient trying to get through a staff door that had been left open. As a result the practice had implemented a new policy relating to security.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Clinical staff had undergone child protection training to Level 3, and all other staff to Level 1. Adult safeguarding training had been provided to the staff team by the GP principal and by the local carers group. The GP principal was the appointed practice lead in safeguarding vulnerable adults and children. The administrative staff we spoke with were able to describe what safeguarding was. They were also aware of their responsibilities and knew to raise safeguarding concerns with the GPs.

We were told safeguarding scenarios were discussed with staff during practice meetings, and we saw minutes to confirm this. There was a safeguarding children policy in place which identified the GP principal as the lead and the practice nurse as the deputy lead. This policy was last reviewed in January 2014. It contained the details of the local safeguarding team and their contact numbers, including those for out of hours concerns. These numbers were also available in the reception area. The policy relating to safeguarding adults required updating so that it contained the most up to date contact numbers for the safeguarding team.

There was a system to highlight vulnerable patients on the practice's electronic records. If a child protection concern flagged up, staff could also use the system to highlight if there were any other children living in the same household. We were told that staff would always record who a child came into the practice with and we saw evidence of this on patient records.

There was a chaperone policy, and notices on both consulting room doors advising patients they could request a chaperone. (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). Staff had not received any formal training and one non-clinical staff member we spoke with was unaware of their responsibilities – for example where they should stand if they were acting as a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked the medicine refrigerator which was in the practice nurse's room and found medicines were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, however this had not been reviewed since 2012. Records showed fridge temperature

checks were carried out daily by the practice nurse which ensured medicines were stored at the appropriate temperatures. The refrigerator was cleaned every three months and there was a backup refrigerator available. Both had been calibrated in December 2014.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a repeat prescription protocol on display in the administrative office. Administrative staff were able to describe how they followed this protocol. The practice's computer system would flag up any patient who needed a medicines review. One month before the review is due patients were reminded by an alert written on their prescription. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. If a handwritten prescription or one without a barcode was issued the local pharmacist would telephone the practice to confirm it was legitimate. Patients could order repeat prescriptions online, and there was a box in reception if they wished to drop them in. We noted that there was no information in reception to inform patients what the turnaround time for a repeat prescription was.

We were told the GP principal and practice manager met with the local pharmacist every three months. Medicine audits had been undertaken. For example one with regard to reducing medicines wastage, and another with regard to the repeat prescription process. Neither had been re-audited to complete the audit cycle.

We were told the management of patients prescribed high risk medicines such as methotrexate was undertaken by the hospital which had been the initial prescriber. An alert was placed on any such patient's record so that practice staff were aware.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were up to date.

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. An infection control policy was available for staff to refer to. This had last been reviewed in January 2014.

A practice nurse and the GP principal were the leads for infection control. Staff had received training and the practice carried out an in-house infection control audit every six months. The last one had been carried out on 9 January 2015 and had identified a number of areas that needed to be addressed including providing aprons for staff; placing pedal bins in clinical rooms and informing staff that they should wear gloves if handling specimens. All these areas had been actioned. The practice had also undergone an infection control audit from NHS England on 26 January 2015. This audit had identified that some flooring and sinks required replacing, with a timescale for completion of one year. A chair also required replacing and this had been done.

Notices about hand hygiene techniques were displayed by sinks. Hand sanitiser was available throughout the practice. There was a spillage kit available and personal protective equipment such as disposable gloves. Privacy curtains were provided and these were wipeable and easy to clean. Clinical waste bins were available as were sharps boxes.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). A risk assessment for legionella had been undertaken on 26 January 2015 which had identified some issues. The assessment had been forwarded to the building landlord for action.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 7 October 2014. A schedule of

testing was in place. We saw evidence of calibration of relevant equipment in December 2014; for example weighing scales, nebuliser, blood pressure measuring devices, ECG machine and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for staff employed post the introduction of the 2012 legislation. Staff employed before this date had not been required to provide a CV for example. All staff bar one administrative member of staff had undergone the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). An application was in progress for the one outstanding check.

We spoke with a newly recruited member of staff. They confirmed they had received an induction and had completed some basic training in health and safety, safeguarding and infection control.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building. We were told, and records confirmed, that, for example, fire drills were carried out every six months. We saw the practice had servicing and maintenance records in place. The practice manager told us they carried out a visual health and safety check every day; and every three months checked the fire alarms, extinguishers and emergency torches. The practice also had a health and safety policy which was last reviewed in December 2014. All staff had training in health and safety and fire safety. Health and safety information was displayed in the reception office for staff to see.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The last calibration had been in December 2014. We checked that the pads for the automated external defibrillator were within their expiry date. The practice did not have oxygen. We were told that this was because the local CCG had informed them it was not essential however the GP principal ordered a portable oxygen cylinder whilst we were completing the inspection.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had three trained first aiders, and their names and the location of the first aid box were on display in the reception office.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, staff shortages and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the water supplier to contact if the water system failed. The plan was last reviewed in September 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP principal could clearly outline the rationale for their approach to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE). They told us that NICE guidance was discussed in practice meetings with clinicians when required. For example, they had recently discussed the drug interaction of statins with clarithromycin.

The GP principal described how they carried out assessments which covered all health needs and was in line with these national and local guidelines. The GP commented that clinical staff worked together at the practice to ensure NICE guidance was followed. For example, the practice nurse would check a patient's blood pressure and BMI (body mass index) and then they would transfer them to the GP to discuss the patient's medical concerns and medicines.

Staff told us that as they were a small practice that supported each other. Staff commented that they found the GP principal to be very approachable. External support was also used, for example the local pharmacist visited the practice every quarter to review the practice's prescribing and provided the practice with benchmarking data which the GP told us they evaluated. The diabetic nurse visited every two weeks.

Patients with long term conditions were regularly reviewed. For example those with hypertension had their blood pressure monitored, their medicines reviewed and they were given guidance regarding a healthy lifestyle. The practice had exceeded its QOF target for the number of patients with a blood pressure reading of under 150/90 achieving 82% (target of 80%).

Elderly patients discharged from hospital were reviewed by the local STARRS team (short-term assessment, rehabilitation and re-ablement service), an initiative funded by the local CCG. The practice received a fax from the hospital to notify them of this. Patients were supported by the team for up to 14 days post discharge. During this time they had access to district nurses, physiotherapy and occupational therapy input where required.

The practice had a large number of patients with diabetes who required insulin. Patients were referred to a specialist diabetic nurse and could also be referred to a dietician. One of the practice nurses had received additional training in diabetes management.

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

Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The audits related to cervical smears; thyroid replacement therapy and diclofenac (a nonsteroidal anti-inflammatory drug). We saw that audit outcomes were discussed with other staff in practice meetings.

The practice carried out joint injections and we saw that appropriate records were being kept. Seven patients had received treatment over the past year.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding thyroid hormone replacement. The initial audit showed 66% of relevant patients were receiving adequate replacement. Following a focussed recall exercise, a re-audit showed that the figure had risen to 88%.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. It achieved 95.5% of the total QOF target in 2014 (859 points out of a possible 1000), which was above the national average of 93.5%. Specific examples to demonstrate this included the practice's performance for asthma related indicators was better than the national average, and its performance for mental health related and hypertension QOF indicators were also better than the national average. However the

practice had below average outcomes for the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months, achieving 60.77% compared to the national average of 77.75%. It was also below the national average for the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) achieving 0.05% compared to 0.61%.

The practice was aware of all the areas where performance was not in line with national or CCG figures. We were told that the practice had just two patients with COPD whose condition was well controlled; and that most of the 152 patients with diabetes were elderly, required insulin and were not always compliant with their medication. Both practice nurses had training in managing diabetes and the practice was visited fortnightly by a specialist diabetic nurse. The GP had also undergone training in diabetes and a dietician visited the practice every two months to give advice.

There was a protocol for repeat prescribing which followed national guidance. The practice had carried out an audit of diclofenac (a nonsteroidal anti-inflammatory drug (NSAID)) prescribing to assess if alternative NSAID's, with potentially less harmful side effects, had been discussed with the patient. The audit had shown that 34 patients were prescribed this NSAID. As a result of the initial audit four patients had their prescription changed, whilst for 15 the prescription had been for a singular treatment of muscular pain, and 15 patients had tried alternatives which had not been effective. A re-audit eight months later had shown that whilst there were still a number of patients with a regular prescription for diclofenac, all patients were now aware of the potential side effects.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

All palliative care patients had a care plan and we viewed one of these on the computer system. This was patient centred and up to date.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as infection control, health and safety, fire safety, CPR and safeguarding.

The GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

As the practice was a training practice, medical students were placed at the practice twice a year. They practiced under the supervision of the GP.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It could access blood test results carried out by the local hospital online; and received letters and discharge summaries electronically. Any correspondence that came in as hard copy was scanned into the relevant patient's record and if urgent immediately given to the doctor. The GP was responsible for checking and actioning all incoming information. Staff told us that they were given verbal instructions by the GP if they needed to action anything, such as booking an appointment or diarising a recall.

The practice had seven patients on its palliative care register. We saw minutes of the bi-annual meeting the GP had with the palliative care nurse. We were told that liaison with health visitors was problematic as they did not visit the practice. Patients requiring district nurse input were advised to contact the district nurses directly.

The GP did not routinely liaise with the local social service department (SSD) however they had the contact information should they need to do so. For example, they had contacted the SSD when they realised the children of a newly registered family were not attending school.

The practice held multidisciplinary team meetings every three to four months to discuss patients with complex

needs. For example those with end of life care needs. These meetings were attended by the practice nurses, the GP and a specialist palliative care team. Minutes of these meetings were provided for us to review.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner, and the practice informed the out of hours provider of any patients receiving palliative care. Information was faxed by the out of hours provider every morning and followed up with electronic copies.

The GP used national standards for referrals and was able to talk us through, for example, the national guidelines for suspected bowel cancer. Referrals were mostly completed online. The choose and book system was used for routine referrals. Patients were given an access code and password so that they could arrange an appointment at a time convenient to them. Urgent referrals using the two week wait rule were faxed and the patient given a copy with advice to call the practice if they had not been given a date within that timeframe.

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

Consent to care and treatment

We found that the GP was aware of the Mental Capacity Act 2005 and their duties in fulfilling it. They explained how they supported patients with a learning disability or dementia to be involved in drawing up their care plans. For example, the GP principal had worked with a consultant psychiatrist in assessing the capacity for a patient with learning disabilities. It was determined that the patient had capacity to make their own decisions.

The practice has signed up to the local enhanced service for patients with a learning disability. All of the patients on the practice's learning disability register had received an annual review. The GP principal had undergone specific training in learning disabilities.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were informed if patients had long term conditions or required medication. We noted the GPs and nurses used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers. For those patients who had been smoking for over 15 years spirometry (lung function) tests were carried out. The practice had 370 smokers and had offered support to stop to 78% of them.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. These were carried out by the GP and the practice nurses.

We were told that the practice had a particular focus on coronary heart disease (CHD). We saw information displayed in the waiting room which set out the practice's 'plan of action' which was to set up specific CHD clinics; run health promotion sessions for patients and to act as a resource for CHD patients and also staff.

The practice was part of the Harrow integrated care planning pilot and met monthly with a care co-ordinator to assess the needs of patients with long term conditions.

The practice's performance for the cervical screening programme was 74%, which was below its target of 80%. There was a policy to call patients who did not attend for their cervical screening test, and then send written reminders if they still did not attend.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Last year's performance was below average for the majority of immunisations where comparative data was available. For example, flu vaccination rates for the over 65s was 68.29%, and at risk groups 69.65%. The rates for the over 65s was below the national average of 73.24%, whilst that for at risk groups was above the national average 52.29%. More specifically, 97% of patients with CHD had been vaccinated, as had 78% of patients who had had a stroke or trans ischaemic attack, 85% of patients with diabetes and 100% of patients with chronic obstructive pulmonary disease.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given to under twos was 84% and five year olds was 66%. These were below national averages. There was a variety of health promotion leaflets and literature available to patients in the waiting room and the nurses room.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, a survey of 50 patients undertaken by the practice and feedback through the 43 CQC comment cards received. The practice did not have a patient participation group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed mixed results. Whilst the practice achieved outcomes in line with the CCG and national average for how well the GP explained treatment, involved patients in their care and treated them with care and concern, it fell below the CCG and/or national averages in other areas. For example 75% said the GP was very good at listening to them compared to the CCG and national average of 87%. Seventy two percent said the GP gave them enough time compared to the CCG average of 83% and national average of 85%. Eighty seven percent said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and national average of 92%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 43 completed cards and all but one were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect and that the premises were hygienic. One patient commented that it was sometimes difficult to get an appointment quickly. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Consultations and treatments were carried out in the privacy of a consulting room. Screens and curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. A screen at the reception desk could be closed to prevent patients overhearing conversations, and patients could request to speak to staff in an adjacent area if they wished to have more privacy. In the national patient survey 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example 80% said the last GP they saw was good or very good at explaining tests and treatments compared to the CCG average of 79% and national average of 82%. Sixty seven percent said the last GP they saw was very good at involving them in decisions about their care compared to the CCG average of 70% and national average of 75%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations.

Staff told us that translation services were available for patients who did not have English as a first language. We observed staff talking to patients in languages other than English.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 68% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 83%. Seventy seven percent said the last nurse they spoke to was good at treating them with care and concern

Good

Are services caring?

compared to the CCG average of 70% and national average of 78%. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Where appropriate the GPs referred patients to emotional support services such as the Improving Access to Psychological Therapies (IAPT) service. The practice also made patients aware of the 'Big Wide Wall' which was a service funded by the CCG and enabled patients to chat online to discuss and share their issues. Cognitive behavioural therapy was also available through this service. The practice referred appropriate patients to the memory clinic, although it could take up to nine months for a place to become available.

The practice maintained a register of carers and offered support and information to them. None of the patients we spoke with had needed a referral to emotional support services, and it was not raised in the comments cards we received back.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, arrangements were in place to have a female doctor provide consultations one day a week to cater for those patients who preferred not to see a male doctor. We spoke with some female patients on the day of the inspection. They confirmed that they could see a female GP although they may have to wait longer for such an appointment.

The practice did not have a patient participation group, or PPG (a PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), but had carried out its own patient survey. This had highlighted that patients felt it was difficult to get through to the practice by telephone; and patients preferred therefore to book appointments in person. As a result the practice had added an additional receptionist to cover the busy morning periods. It had also introduced online booking. The practice was also advertising that patients could download an 'app' which would enable them to book an appointment via the national 'Patient Access' booking system. Patients had also requested weekend opening however the GP felt this was financially not possible. They had however increased the morning clinic by one hour; the afternoon clinic by 30 minutes and on Fridays had introduced extended hours until 7.30pm. Improvements in the system were reflected in the results of the national patient survey 2014 where the practice exceeded the CCG and national average for patients' satisfaction with the ease of making an appointment - 90% said they could get through easily to the surgery by phone compared to the CCG average of 64% and national average of 72%.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, home visits and telephone consultations were available for patients who required them. There were seven patients registered at the practice who were housebound and the GPs liaised with the district nurses to provide care for them. Longer appointments were available for patients with complex needs, the elderly, patients with a learning disability and those with mental ill health.

The practice had a diverse population, including those with Eastern European and Asian languages. The GP spoke five languages, whilst other staff members also spoke a range of languages between them. Staff had access to online and telephone translation services if they were needed. A hearing loop was available. There were accessible toilets and baby changing facilities. The waiting room was large enough to accommodate wheelchairs and pushchairs. The practice had a consulting room on the ground and the first floor of the premises. Staff told us they would ensure those patients with mobility difficulties would always be seen in the ground floor room.

Access to the service

The surgery was open on Mondays, Tuesdays and Thursdays between 08:30 – 15:30 and 16:30 – 18:30. On Wednesdays it was open from 08:30 – 14:00, whilst on Fridays between 08:30 – 15:30 and 17:00 – 19:30. Appointments could be booked online, by telephone or in person. Emergency appointments were available every day.

Information was available to patients about appointments on the practice website. This included how to book appointments through the website; details about the services provided; the staff available; a patient feedback form and health information including a symptom checker. Information about booking appointments and the out of hours service was available in the practice leaflet. If patients called the practice when it was closed, the answerphone message gave the NHS 111 number to call for urgent medical assistance. Information on the out-of-hours service was available on the website.

There was a range of information available in the waiting room including a poster describing how patients could use the online services to book and cancel appointments, order repeat prescriptions, view their medical records and make changes to their personal details. Patients were informed there was an interpreting service available; that a chaperone could be provided if requested and they were given information relating to health promotion such as

Good

Are services responsive to people's needs?

(for example, to feedback?)

smoking cessation and an over 65 years of age fitness group. A number of leaflets were provided, for example regarding complaints, the Harrow community stroke programme, vaccinations and NHS screening.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

The national patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example, 76% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 73%. Seventy eight percent said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 50% and national average of 65%. Ninety five percent said their appointment was fairly or very convenient compared to the CCG average of 86% and national average of 92%.

Patients we spoke with were satisfied with the appointments system. They told us they usually called into the practice or telephoned.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system – a leaflet on complaints and comments was available in the waiting room. Patients we spoke with said they would speak to staff if need be. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received three complaints during the preceding 12 months. We saw the practice reviewed complaints received annually, identified learning points and logged the action taken; and shared these findings with the staff team. We saw minutes of staff meetings which confirmed this.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice vision, as described by the GP, was to provide patient centred care and offer greater patient choice. They added they wanted to increase the practice size, and to target patients with coronary heart disease as it was very relevant to the patient population. Staff were able to describe how they contributed to patient centred care, but were not specifically aware of the vision and values as they had not been formally documented.

Governance arrangements

The practice had a number of policies and procedures in place and staff were aware how to access them.

There was a clear leadership structure with named members of staff in lead roles. The GP and the practice manager told us they regularly discussed governance but this was informal and no minutes were recorded. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

The GP and practice manager were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff.

We saw from minutes that practice meetings were held every month. The GP principal attended monthly peer meetings whilst the practice manager attended monthly practice manager forum meetings. We also saw minutes of these meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. There was an employee handbook, which was accessible on a shared drive in the practice. However, not all staff were aware of this. A whistleblowing policy was in place. It was last reviewed in December 2014 and detailed the internal and external procedures for staff to follow if they had any concerns. Not all staff were aware of this policy.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through surveys and complaints received. The GP showed us the analysis of the last patient survey, carried out in January – March 2014, which had sought the views of 50 randomly selected patients. The results were shared during staff meetings. For example, as a result of patient complaints about the difficulty in getting through on the phone in the mornings, an additional receptionist was added to answer phones.

The practice had also gathered feedback from staff through staff meetings and annual appraisals. Staff told us they felt comfortable to give feedback and discuss concerns and they felt involved in making improvements to benefit patients. They were able to give us an example where the practice manager had adopted a suggestion to improve how they dealt with hospital requests for patient summaries.

Management lead through learning and improvement

Staff told us that the practice supported them with learning and training. We saw appraisals had been carried out and personal development plans were in place.

The practice had a teaching agreement with a London school of medicine and offered placements to medical students. Feedback from students was complimentary. The GP shared case studies for learning at the peer group meetings he attended with other local practices.