Dr Anil Indwar

Quality Report

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

Ratings

Overall rating for this service	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Anil Indwar (also known as Walford Street Surgery) on 23 June 2017. The overall rating for the practice was good. However, we rated the practice requires improvement for providing well-led services. The full comprehensive report on the June 2017 inspection can be found by selecting the 'all reports' link for Dr Anil Indwar on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 22 November 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 23 June 2017. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is rated as good.

Our key findings were as follows:

- There were six patents on the practices dementia list and examples we looked at showed that the practice used hospital letters which outlined the management of the patient as part of their care plan. Evidence we looked at showed that there was enough information to deliver effective care and family members had an input in the plan where appropriate.
- The practice held a register of patients on the palliative care list and we saw evidence of discussion at multidisciplinary meetings. Information to deliver appropriate care to the patient was embedded into the patient record system. However, key information such Do Not Attempt Cardiopulmonary resuscitation (DNACPR) and patient's wishes for end of life was not immediately accessible which would be useful for other clinicians such as out of hours doctors or locum GPs.
- The practice had established a formal recording process for clinical supervision. The practice nurse and the GP met formally most Fridays to discuss case reviews of complex patients.
- We looked at three recruitment files and saw that appropriate recruitment processes had been followed.
- We spoke with two staff members and they demonstrated adequate knowledge of the role of a chaperone. We looked at training records which showed that staff had completed chaperone training.

Summary of findings

- The practice had assessed the premises to consider access for patients who had difficulty with their mobility. We saw that appropriate action had been taken and arrangements were in place to signpost patients elsewhere if they were unable meet their needs at the practice.
- We saw evidence of actions taken to improve the uptake of national screening programmes for breast and bowel cancer. The practice was working with a representative from the screening services at the Clinical Commissioning Group (CCG). Evidence we looked at showed that improvements were being made to the number of patients engaging with the screening programme.

In addition the provider should:

- Make key information such Do Not Attempt Cardiopulmonary resuscitation (DNACPR) and patient's wishes for end of life easily accessible on the patient record system for the benefit of other care providers such as the out of hours clinicians and locum GPs.

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 well-led?

Good

At our previous inspection on 23 June 2017 we rated the practice as requires improvement for providing well-led services. The practice had a governance structure but we also identified areas for improvement in relation to service improvement activity and in the monitoring of the service. At this inspection we saw that the practice had made improvements and is now rated as good.

- We saw four two cycle clinical audits which demonstrated quality improvement. For example, the diabetes audit we looked at demonstrated that only 45% of patients had been referred to structured education programme to help them to manage their condition. A re-audit showed that the practice had increased this to 90%.
- Medical oxygen was available and checked regularly to ensure it was safe and available to use. There were spill kits available for use in the event of a spillage and we saw that the contents were in date.
- The practice had assessed the premises to consider access for patients who had difficulty with their mobility in September 2017 and actioned areas identified for improvement.
- Records of meetings we looked at showed that the GP and the practice nurse met regularly to discuss and review complex cases.

The practice had established a Patient Participation Group (PPG) and action was being taken to improve service following feedback received from the last meeting held in August 2017.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Make key information such Do Not Attempt Cardiopulmonary resuscitation (DNACPR) and patient's wishes for end of life easily accessible on the patient record system for the benefit of other care providers such as the out of hours clinicians and locum GPs.

Dr Anil Indwar

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 specialist adviser and a second CQC inspector.

Background to Dr Anil Indwar

Dr Anil Indwar's practice (also known as Walford Street Surgery) is part of the NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice is located in a residential property that has been adapted for the purpose of providing primary medical services. Clinical services are provided on the ground floor of the premises. There is limited parking available at the front of the building however, parking is also permitted on the street. The practice's registered list size is approximately 2300 patients.

Based on data available from Public Health England the practice is located in an area with higher levels of deprivation than the national average (within the 30% most deprived areas). The population age distribution of the practice broadly follows the national average.

The practice has a general medical service (GMS) contract with NHS England. Under the GMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

The practice is owned by a single handed GP (male), currently supported by a long term locum GP (male) who had been working at the practice since December 2016. Other practice staff includes a practice nurse (female), a practice manager and a team of administrative staff.

The practice is open Monday to Friday 8am to 6.30pm with the exception of Wednesday afternoons when the practice closes at 1pm. On a Wednesday afternoon the practice has reciprocal arrangements with another local practice for patients to be seen there. Consulting times are between 8am to 12 noon and 4pm to 6pm. When the practice is closed services are provided by an out of hours provider which can be accessed through the NHS 111 telephone service.

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Anil Indwar on 23 June 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as good overall. However, it was rated as requires improvement for providing well-led services. The full comprehensive report following the inspection on June 2017 can be found by selecting the 'all reports' link for Dr Anil Indwar on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Dr Anil Indwar on 22 November 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

Detailed findings

How we carried out this inspection

We carried out a desk-based focused inspection of Dr Anil Indwar on 22 November 2017. During our visit we:

- Spoke with a range of staff including the practice manager, practice nurse, the provider GP and administration staff.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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

Are services well-led?

Good

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

Our findings

At our previous inspection on 23 June 2017, we rated the practice as requires improvement for providing well-led services. The practice had a governance structure but we also identified areas for improvement in relation to service improvement activity and in the monitoring of the service.

We issued a requirement notice in respect of these issues and found arrangements had significantly improved when we undertook a follow up inspection of the service on 22 November 2017. The practice is now rated as good for being well-led.

Governance arrangements

During our previous inspection in June 2017 we found that the practice had an overarching governance framework to support the delivery of the service. However we also found areas for improvement such as completed audit cycles, regular supervision of the practice nurse as well as engagement with patient groups to improve delivery of service.

During this inspection we looked at four clinical audits (on diabetes, hypertension, gout and repeat prescribing) which were all two cycle audits. Although they had been carried out within a short space of time, they demonstrated quality improvement. For example, the diabetes audit we looked at demonstrated that only 45% of patients had been referred to a structured education programme to enable them to manage their condition. A re-audit showed that the practice had increased this to 90%.

During our previous inspection in June 2017 we found spill kits that were out of date and oxygen that was in need of replacement. At this inspection the practice had ensured medical oxygen and spill kits were in date and had introduced systems which ensured that these were now being checked regularly.

Since our previous inspection we saw evidence that the practice had assessed the premises to consider access for patients who had difficulty with their mobility. The practice was located in a converted house and was aware of its limitations for patients who used a wheel chair. However, it had carried out an access audit in September 2017 and had identified areas for improvement. For example, it had installed a call bell outside so that patients using a wheel chair could call for assistance from staff. There was a mobile ramp available and home visits were offered to patients that were unable to attend the practice. The practice was participating in hub working arrangement where patients could attend another practice for appointments from 6.30pm to 8pm Monday to Friday as well as Saturday and Sunday mornings. This practice was based in a purpose built premises which enabled easy access for patients who had difficulty with their mobility. The practice manager told us that they had arrangements to signpost any patients to that practice if they were unable to meet their needs at their own practice.

We saw records of formal clinical discussions that were held with the GP usually on Fridays. These were used for care review and to discuss complex cases. The nurse was currently training to become a prescriber and as part of this training they were also required to be formally supervised as part of their learning.

Seeking and acting on feedback from patients, the public and staff

Since our previous inspection we saw that the practice had established a Patient Participation Group (PPG) consisting of four members. Minutes of a meeting we looked at showed that the PPG had met on 18 August 2017 and further meetings were planned. There were posters in the reception encouraging patients to become part of the PPG and the practice manager was able to show that a patient had recently left their details as they wanted to become part of the group. An area of feedback from patients was that they had difficulty with telephone access. The practice had listened and we were told that a new telephone system was being installed. This system had call waiting facility as well as other functions such as the number of patients waiting and ability to provide information on peak demand. The practice had also conducted in-house surveys which showed positive feedback for GPs.

The practice explained that they did not receive much feedback through the NHS Friends and Family Test (FFT). This was also noted during our previous inspection and the practice explained that they continued to face a challenge to get patients to engage with the process and provide feedback. For example, the practice had received only two responses for August 2017. One patient (50%) stated that they were extremely likely to recommend the practice while another (50%) patient stated that they were likely to recommend the practice to friends and family.