Dr Abubakr Shaikh

Quality Report

3 Peel Precinct
Carlton Vale
London
NW6 5RE
Tel: 020 7372 2172
Website: www.peelprecinctsurgery.co.uk

Date of inspection visit: 5 November 2014
Date of publication: 26/03/2015

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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Abubakr Shaikh on 5 November 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective and well-led services. It also required improvement for providing services for all six population groups: 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; and people experiencing poor mental health (including people with dementia). The practice was good for providing a caring and responsive service.

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

- The practice worked in collaboration with other health and social care professionals to support patients' needs.
- Risks to patients were assessed but systems and processes to address these risks were not implemented well enough in relation to infection control, recruitment, safety and suitability of premises and dealing with foreseeable emergencies.
- Arrangements were in place to ensure staff were competent to deliver effective care and treatment but there were some gaps in the training undertaken and not all staff had received a recent appraisal.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice understood the needs of its patients and was responsive to these. It recognised the needs of different groups in the planning of its services.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

Summary of findings

The areas where the provider must make improvements are:

- Take action to address identified shortcomings with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Arrange regular health and safety and fire risk assessments, fire alarm testing and fire evacuation drills to ensure the safety and suitability of the premises.
- Take action to address identified shortcomings in the provision for medical emergencies and arrange relevant training for all staff in accordance with UK Resuscitation Council guidelines.
- Ensure identified gaps in staff training are addressed and annual appraisals are conducted for all staff.

In addition the provider should:

- Place significant events and complaints as a standing item on the agenda for practice meetings to demonstrate that the lessons learned from incidents and complaints have been communicated throughout the practice.
- Arrange for all staff to complete formal training in safeguarding of vulnerable adults.
- Complete a documented risk assessment stating the rationale for not carrying out a criminal records check for some non-clinical staff.
- Take steps to communicate the practice's chaperone policy more clearly to patients.
- Ensure non-clinical staff who occasionally act as chaperones undergo a criminal records check.
- Formally record the checks of medicine expiry dates and medical emergencies equipment.
- Install an emergency pull cord in the patients' toilet.
- In addition to annual calibration checks carried out currently, arrange regular testing of portable appliances to ensure equipment is safe and suitable.
- Review practice policies and procedures in a systematic way to ensure they remain up to date and relevant and where model policies had been obtained from external sources these are tailored specifically to the practice in all aspects.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Risks to patients were assessed but systems and processes to address these risks were not always implemented well enough to ensure patient safety.

We saw evidence in significant events investigation reports that the outcome and learning was communicated to relevant staff. We were told that significant events were also discussed at practice meetings. However, we did not see this in minutes of the meetings we reviewed and there was no a standing item on the agenda for these events.

The practice had a policy for the safeguarding of vulnerable adults and staff we spoke with knew how to recognise signs of abuse and the process to follow if they suspected abuse. However, none of the staff had completed formal training in this area. A chaperone policy was in place and staff we spoke with understood their responsibilities when acting as chaperones. However, some non-clinical staff who occasionally acted as chaperones had not undergone a criminal records check.

Medicine expiry dates were monitored but no record was kept of checks carried out. Emergency medicines were kept in the GP's consulting room but when the GP was away from the practice the room was locked. This meant that staff did not have ready access to the medicines in the event of an emergency.

There was an infection control policy in place and we observed the premises to be clean and tidy. However the infection control policy required updating; there was no cleaning schedule in place; and we did not see evidence that all staff had received up to date infection control training in line with national guidance. In addition, the practice had not carried out an assessment of the risk of Legionella in line with national guidance, and the body fluid spillage kit was out of date.

A range of pre-employment checks had been carried out on staff before they started working. However, criminal records checks for the GP and two nurses had been carried out some years ago. No check had been carried out for one of the nursing staff and four members of non-clinical staff. There was no documented risk assessment stating the rationale for not checking these staff.

Summary of findings

The practice had a health and safety policy and carried out visual inspections of the premises and equipment on a daily basis. However, the practice had not conducted a recent health and safety risk assessment of the building and environment.

There had been no recent portable appliance testing (PAT) of electrical equipment and there was no schedule of testing in place to ensure that patients, staff and visitors were fully protected against the risks of unsafe or unsuitable equipment.

There was no oxygen available in the practice's medical emergency equipment which was not in accordance with UK Resuscitation Council guidelines. Regular checks were carried out on the emergency equipment but the checks were not recorded. We were told the nursing staff had received training in medical emergencies but this was not recent and there was no documentary evidence of this. Four administrative staff had not received training in accordance with UK Resuscitation Council guidelines.

The practice had a fire safety protocol and staff fire safety was covered in the induction process. However, there was no documentary evidence that staff had undertaken fire safety training. The practice had not carried out a recent fire risk assessment of the premises. The fire alarm was checked and tested twice a year by the contractor but no regular tests were carried out by the practice between these checks. There was no planned schedule of fire evacuation drills and none had taken place recently.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. There were arrangements in place to support staff appraisal, learning and professional development. However, the practice had not completed recent appraisals for nursing staff. There were arrangements in place for staff to receive mandatory training and additional learning and development identified as part of the appraisal system. However, there were some gaps in training administrative and nursing staff had received. The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment. The practice promoted good health and prevention and provided patients with suitable advice and guidance. The practice offered a full range of immunisations for children.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the national GP patient survey showed the practice was rated above the CCG average for care and concern and on consultations with

Summary of findings

doctors and nurses. Satisfaction scores from the practice's own patient survey were less positive in similar areas. However, feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect. We observed this during the inspection and saw that confidentiality was maintained. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The practice provided appropriate support for end of life care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the needs of its patients and was responsive to these. Data from the national GP patient survey showed the practice was rated amongst the best in the CCG area for experience of making an appointment but below average for waiting time to be seen. The views from patients we spoke with and who completed comment cards were mostly positive about access to the service. The practice had taken a number of steps to improve accessibility in the light of feedback. There was an effective complaints system. Lessons learned were communicated throughout the year when individual complaints were concluded. However, we did not see evidence of this in the minutes of practice meetings we reviewed and complaints were not a standing item on the agenda.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had a vision and mission statement. Not all staff were aware of the statement, but they were able to articulate the essence of what it contained and it was clear that patients were at the heart of the service they provided. There was an open culture, staff had clearly defined roles which they knew and understood and felt supported in their work. However, nursing staff had not received refresher training in a number of areas or had a recent appraisal.

The practice proactively sought feedback from staff and patients including a patient participation group (PPG). The GP regularly reviewed and updated Quality and Outcomes Framework (QOF) data throughout the year but we did not see evidence that the data was discussed with the rest of the practice team and there was no formal action plan in place to improve QOF scores. The practice had arrangements for identifying, recording and managing risks including monitoring and review of risks to individual patients. There was a business continuity plan, to respond to and manage

risks in the event of major disruption to the service. However, no recent health and safety or fire risk assessments had been completed in the practice to ensure the safety and suitability of the premises.

The practice had a number of policies and procedures to govern activity. Some policies were model policies obtained from external sources which needed further development to tailor them specifically to the practice. In addition electronic copies of human resource policies were not readily accessible to staff on the practice's computer system. The practice's policies and procedures were updated on an ad hoc basis to take account of new developments and changes. However there was no formal schedule in place for their regular review.

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

Requires improvement

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, older people. The practice used a risk stratification tool approved by the CCG to support practices in case managing their high risk patients, for example in relation to unplanned hospital admissions. The practice was part of a local pilot for the integration of health and social care for patients. The pilot was set up with the intention of improving care for specific groups, including those over the age of 75 years. Home visits were carried out for older patients who were not well enough to attend the surgery. Longer appointments were available to patients who needed them. There were appropriate end of life care arrangements in place.

People with long term conditions

Requires improvement

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, people with long term conditions. The practice provided services for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance. Patients with repeat prescriptions were asked to see the doctor annually to review their medication. The practice participated in a number of prescribing audits led by the CCG, for example in relation to children and adults on high dose inhaled corticosteroids (ICS) for asthma. The GP met with district nurses, care-coordinators and health visitors to help establish best care for patients with long term conditions. The practice was part of a local pilot in for the integration of health and social care for patients. The pilot was set up with the intention of improving care for people in specific groups, including patients with diabetes. Flu and pneumococcal vaccinations were offered to patients in at risk groups, including patients with long term conditions. For patients with long term conditions, home visits were available and longer appointments provided when needed.

Families, children and young people

Requires improvement

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this

Summary of findings

population group, families, children and young people. The practice provided ante and post natal and child surveillance clinics. There was also a family planning service, including smear testing. The practice's performance for cervical screening was 76% in 2013/14. The practice offered a full range of immunisations for children. Flu vaccination was offered to pregnant women. The practice participated in a number of prescribing audits led by the CCG, for example in relation to children and adults on high dose inhaled corticosteroids (ICS) for asthma. There were procedures in place to safeguard children and young people from abuse. All clinical and all but one of the non-clinical staff had completed up to date child protection training in line with national guidance. However, the record for one nurse was not available at the inspection to confirm the training undertaken.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, working-age people (including those recently retired and students). The practice was accessible to working people. For example, the practice operated extended hours on Monday and a two-hour surgery on Saturday morning. In addition, the practice offered telephone consultations and online booking for this group. The practice offered a range of health promotion and screening which reflected the needs for this age group. The practice offered all patients in the 40-74 age group a health check. All newly registering patients were invited to a new registration consultation with the practice nurse to help identify and plan their medical needs. The practice carried out screening of all patients over age 65 for atrial fibrillation. The risk of stroke was assessed and the need for anti-coagulants determined. The GP and nurses provided dietary advice and information for patients on healthy eating. Patients were referred to a dietician for additional support where appropriate. The GP provided smoking cessation advice opportunistically during appointments. Flu vaccination was offered to patients over the age of 65.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, people whose circumstances may make them vulnerable. The practice had an open policy towards registration and vulnerable groups such as homeless patients and street sex workers. Physical health checks were provided for patients with

Summary of findings

learning disabilities. Staff knew how to recognise signs of abuse in vulnerable adults and children and the process to follow in the event of any safeguarding concerns. However, none of the staff had completed formal training in this area. The staff at the practice spoke many different languages which enabled them to communicate readily with most patients. However, if needed translation services were available for patients who did not have English as a first language. The premises and services had been adapted to the needs of patients with a disability.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement in the key questions of safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group, people experiencing poor mental health (including people with dementia). The practice participated in a CCG commissioned direct enhanced service (DES) to profile patients who may be at risk of dementia. Regular reviews and medication management plans and recall protocols were in place for patients on high risk medicines, including medicines for patients with mental health conditions. Staff had been appropriately briefed about the needs of particular patients. For example, reception staff were aware of the behavioural signs to watch for patients with poor mental health and how to respond to minimise avoidable distress during appointments.

Summary of findings

What people who use the service say

We received 45 completed Care Quality Commission (CQC) comments cards providing feedback about the service. On the day of our inspection we also spoke with six patients, including three representatives of the practice's patient participation group (PPG). The majority of patients were positive about the service experienced. Patients felt the practice was safe, clean and hygienic. Patients said they felt the practice offered an excellent, professional service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. These comments were reflected in the national patient survey 2013/14 where the practice scored above the CCG average for patient satisfaction for being treated with care and concern and for satisfaction with consultations with the doctor and nurses. A minority of patients were less positive raising issues such as the need for a female GP, wanting to be contacted about test results that were normal and feeling rushed at appointments.

Members of the PPG we spoke with echoed the mostly positive views expressed by other patients and felt the group was beneficial to the practice. We looked at the patient survey of 65 patients conducted through the group for 2013/2014 and saw that key themes raised included waiting times, access to the doctor or nurse, the need for a female GP, delays in referrals to secondary care and extended evening opening hours. We noted from the group's 2013/14 action plan a number of steps planned to address these issues. These included the practice promoting the increased use of on-line services such as appointments, prescriptions and test results and improving telephone access for appointments.

Areas for improvement

Action the service MUST take to improve

- Take action to address identified shortcomings with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Arrange regular health and safety and fire risk assessments, fire alarm testing and fire evacuation drills to ensure the safety and suitability of the premises.
- Take action to address identified shortcomings in the provision for medical emergencies and arrange relevant training for all staff in accordance with UK Resuscitation Council guidelines.
- Ensure identified gaps in staff training are addressed and annual appraisals are conducted for all staff

Action the service SHOULD take to improve

- Place significant events and complaints as a standing item on the agenda for practice meetings to demonstrate that the lessons learned from incidents and complaints have been communicated throughout the practice.
- Arrange for all staff to complete formal training in safeguarding of vulnerable adults.
- Complete a documented risk assessment stating the rationale for not carrying out a criminal records check for some non-clinical staff.
- Take steps to communicate the practice's chaperone policy more clearly to patients.
- Ensure non-clinical staff who occasionally act as chaperones undergo a criminal records check.
- Formally record the checks of medicine expiry dates and medical emergencies equipment.
- Install an emergency pull cord in the patients' toilet.
- In addition to annual calibration checks carried out currently, arrange regular testing of portable appliances to ensure equipment is safe and suitable.
- Review practice policies and procedures in a systematic way to ensure they remain up to date and relevant and model policies obtained from external sources are tailored specifically to the practice in all aspects.

Dr Abubakr Shaikh

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP, a CQC inspector and an Expert by Experience. An Expert by Experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP and Expert by Experience were granted the same authority to enter Dr Abubakr Shaikh's practice as the CQC inspectors.

Background to Dr Abubakr Shaikh

Dr Abubakr Shaikh is an individual GP who provides primary medical services at the Peel Precinct Surgery to around 1800 patients in the Kilburn area of Brent in North West London. This is the only location operated by this provider. The practice serves a multi-ethnic mix of population who have varied socio-cultural and religious needs. The majority of patients are from a relatively young population group with above national average numbers in the 0-14 and 30-49 years age ranges.

The GP is supported by a team of two part time practice nurses, a part time practice secretary, and five part time receptionists.

There was insufficient data to enable CQC intelligent monitoring to place the practice in a priority banding for inspection. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Brent Council's Executive has endorsed a strategy which will enable the Council to build a new health centre, The South Kilburn Health Centre. The centre will provide new accommodation for Dr Abubakr Shaikh and two other GP practices in the area. If approved the project is expected to be completed by 2017/18.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. 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?

Detailed findings

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 we hold about the practice and asked other organisations to share what they knew. We liaised with Brent Clinical Commissioning Group (CCG) Brent Healthwatch and NHS England. We carried out an announced visit on 5 November 2014.

During our visit we spoke with a range of staff including the GP, a practice nurse, the practice secretary and two receptionists. We spoke with six patients who used the service, including three members of the practice's Patient Participation Group. We observed how people were being cared for, talked with carers and family members and reviewed the personal care or treatment records of patients. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed information that had been provided to us prior to and at the inspection and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, audits and risk assessments and related action plans, staff records and health information and advice leaflets.

Requires improvement

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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient presenting with particular symptoms which required a hospital referral for full examination and diagnosis refused to be referred at the initial appointment. When the patient returned for a follow up appointment the GP succeeded in explaining the seriousness of their condition and referred them to A&E via ambulance. Lessons learned from the incident were reviewed with staff and action identified to ensure the seriousness of the symptoms was communicated unequivocally to the patient and all staff were aware of immediate steps to take if a patient with the symptoms telephoned or came for an appointment.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The GP was the nominated lead responsible for reviewing and distributing any alerts and guidelines to medical staff within the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and staff we spoke with were aware of the process to follow to report significant events within the practice. The practice kept records of significant events and details of these was made available to us for events that had occurred during the last 12 months. Each was investigated noting details of the significant event, action taken, the outcome and any learning and action for the practice. There were no common themes to these events. We reviewed the practice's procedure for handling significant events and saw the form used to report events which included a description of the event, issues arising, the impact on the patient, what went well, what didn't go well, how things might have been done differently, and action learning points. The forms recorded any discussion and dissemination of findings with staff. We were told that any significant events would also be discussed at the practice's quarterly meetings and in regular informal meetings. However, such events were not a permanent item on the agenda of the formal meetings. For example, we did not see reference to a recent event in the minutes of a meeting in August 2014.

Reliable safety systems and processes including safeguarding

The practice had an appropriate child protection protocol in place, including contact details for local child protection agencies. The GP was the nominated lead for safeguarding and staff we spoke with knew who the lead was, how to recognise signs of abuse, the process to follow and who to contact if they suspected abuse. Staff training records indicated that all but one of the non-clinical staff had completed up to date child protection training at level 1. Nursing staff received child protection training at level 2, and the GP at level 3 in accordance with national guidance. However, the record for one nurse was not available at the inspection to confirm the training undertaken.

The practice had a policy for safeguarding of vulnerable adults. However, none of the staff had completed formal training in this area. Staff showed some understanding of how to recognise signs of abuse. The GP had details of local authority safeguarding contacts on computer but these were not in the policy and staff did not have direct access to them. During the inspection the GP undertook to make the contact details available to all staff on the practice's computer system.

Although a chaperone policy was in place, there was no information on display to patients about this. However, patients we spoke with said they were offered a chaperone when appropriate. The chaperone policy contained guidelines about the role of a chaperone and the processes to follow, including records to make in patients' notes. If nursing staff were not available to act as a chaperone administrative staff occasionally undertook this role. Staff we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. However, not all non-clinical who undertook this role had undergone a criminal records check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. Members of the administrative team checked daily to ensure that

medicines were kept at the required temperatures, and were aware of the action to take in the event of a potential failure. The records we saw showed temperatures were within the required range.

The practice maintained medicine stock records and monitored medicine expiry dates. Computer records were kept which flagged when medicine was due to expire. The practice nurse told us these records were checked every three months, although no record was kept of the checks. All the medicines we checked on the day of the inspection were within their expiry dates. The kit containing emergency medicines was kept in the GP's consulting room. When the GP was away from the practice, for example when carrying out home visits, the consulting room was locked which meant that staff did not have ready access to the medicines in the event of an emergency. We discussed this with the GP who undertook to make immediate arrangements to ensure staff could access the kit in his absence.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. Repeat prescriptions could be ordered on-line, by post, or in person at the practice. Patients were asked to allow between 24 and 48 hours for repeat prescriptions to be processed before collection. Patients with repeat prescriptions were asked to see the doctor annually to review their medication. There was an alert system on the GP's computer to ensure reviews took place. Patients we spoke with felt that the repeat prescription system was efficient.

There was a system in place for the management of patients who had been prescribed high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice said regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions.

The practice participated in a number of prescribing audits led by the Brent Clinical Commissioning Group. One example submitted by the practice in pre-inspection information was a review of all children and a sample of adults on high dose inhaled corticosteroids (ICS) for asthma, with the aim of ensuring that they are prescribed the lowest effective dose to maintain asthma control. The audit report included the practice's action plan as a result of the audit which was due for review at the end of December 2014.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. They said the clinical staff washed their hands before and after any physical examination. The practice was cleaned daily but there was no written cleaning schedule in place. The GP told us the need for a cleaning schedule had been identified in a recent infection control audit and was in the action plan for implementation.

The GP was the practice lead for infection control and provided ongoing advice to staff on practice infection issues. A recent externally provided infection control audit had identified that there was no formal infection control training programme for staff on induction or on an annual basis subsequently. We were told that the GP and nursing staff had received infection control training within the last year but no documentary evidence was available of this. As part of the infection control audit action plan the local infection control team was due to visit the practice to provide infection training for all staff.

The recent infection control audit had identified several other shortcomings in infection control practice, including the lack of an up to date infection control policy, no assessment of the risk of Legionella (a germ found in the environment which can contaminate water systems in buildings) and the practice did not have a suitable body fluid spillage kit. The practice was in the process of implementing the audit action plan and had addressed a number of the issues identified. However, the infection control policy needed further development to tailor it to the practice, and action on the Legionella risk assessment was outstanding. In addition, the body fluid spillage kit in the nurse's treatment room was out of date. As a result of these shortcomings, the practice did not comply fully with the Department of Health's 'The Health and Social Care Act 2008: Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance'.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand

soap, hand gel and hand towel dispensers were available in treatment rooms. However, in the patient toilet/baby changing room the hand gel dispenser was on a shelf and not clearly prominent.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment completed in January 2014; for example weighing scales, nebulisers, spirometers, pulse oximeters, and blood pressure monitors. However, the GP confirmed that there had been no recent portable appliance testing (PAT) of electrical equipment and there was no schedule of testing in place to help ensure that patients, staff and visitors were fully protected against the risks of unsafe or unsuitable equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff. However, the practice was unable to provide documentary evidence of interview and selection decisions.

We found a range of checks had been undertaken prior to the employment of staff including proof of identification, references, qualifications and registration with the appropriate professional body.

We were told that criminal record checks had been undertaken for the GP and two of the nursing staff. However, these were done some years ago when staff were employed by the former PCT and documentary evidence of the checks was not available. In addition no check had been carried out for a recently recruited nurse. We saw the check carried out for the practice secretary and were told a check had been completed for one of the reception team but evidence of this was not available at the practice. Criminal record checks had not been carried out for four administrative staff. However, the practice had not completed a documented risk assessment stating the rationale for this decision.

We were told that all staff received a comprehensive induction as part of the recruitment process. We saw the form used for this purpose and staff we spoke with confirmed that they had followed an induction process and been provided with a clear job description which had been effective in helping them take on their new role.

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

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

Monitoring safety and responding to risk

The practice had a health and safety policy. Health and safety information was displayed for staff and patients to see. The practice carried out visual inspections of the premises and equipment on a daily basis. However, these checks were not routinely documented and the practice had not conducted a recent health and safety risk assessment of the building and environment to ensure patients, staff and visitors were fully protected from the risk of unsuitable or unsafe premises.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, we were shown a smear test audit completed for the period March to April 2014. These audits were completed twice a year. The latest audit identified two inadequate smears, equivalent to the national average of 2.8%. The reason for the inadequate smears was given as insufficient material. The action from the audit included a repeat of the inadequate smears, ensuring that all smear takers attended three yearly update training and the continuing audit inadequate smears three monthly and annually. We also saw a recent review of prescribing to patients of high dose inhaled corticosteroids (ICS) used for the long term control of asthma. The action plan from the review included providing patients with asthma with a written personalised action plan and giving them specific training and assessment in inhaler technique before starting any new inhaler treatment.

Requires improvement

Are services safe?

The practice used BIRT2, a risk stratification tool approved by the CCG to support practices in case managing their high risk patients. For example, the tool had been used in relation to unplanned hospital admissions to establish a case management register and put care plans in place for "at risk" patients. Patients on the register were reviewed monthly by the district nursing team.

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including a pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). However, there was no oxygen available which was not in accordance with UK Resuscitation Council guidance and did not equip the practice fully to deal with medical emergencies. All staff asked knew the location of the emergency equipment but it was stored in a cupboard above head height which may inhibit rapid access in an emergency. We saw that all of the equipment was operational. We were told that checks were carried out on the equipment but no record was kept of these checks to confirm this, other than annual calibration checks. The GP and two administrative staff had received training in dealing with medical emergencies in 2013 and we saw the certificates for this. We were told the nursing staff had received such training but this was not recent and there was no documentary evidence of this. Four administrative staff had not received training in accordance with UK Resuscitation Council guidelines.

The provider had a business continuity plan which set out the arrangements to be followed in the event of major disruption to the practice's services. The plan was dated April 2014 and in the event of major disruption to the service made provision for relocation to a neighbouring practice after discussion with Brent CCG**.** It also identified action in the event of loss of computer systems; access to paper records; gas, electricity and telephones; absence of key staff; and access to the building. The plan contained a section of essential contacts but the details for the contacts had not been completed.

The practice had a fire safety protocol and staff fire safety was covered in the induction process. However, there was no documentary evidence that staff had undertaken fire safety training. The practice had not carried out a recent fire risk assessment of the premises. However, the GP told us that they were in the process of negotiating a new contract with a fire services company who were due to carry out a fire risk assessment within the next two weeks. The fire alarm was checked and tested twice a year by the contractor and we saw the latest certificate for this. However, no regular tests were carried out by the practice between these checks. There was no planned schedule of fire evacuation drills and none had taken place recently. The practice ensured, though, that staff were aware of the assembly point outside of the building in the event of an evacuation.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The GP told us he had a special interest in paediatrics, dermatology, cardiology, obstetrics, gynaecology and family planning. He kept his clinical knowledge up to date through continuing professional development, by attending meetings and reading medical journals. He also regularly met hospital and community consultants, nurses, members of primary and secondary healthcare teams and local colleagues to share knowledge in peer review group meetings held at the practice.

We found from our discussions with the GP and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the GP told us of the process followed using NICE guidelines in screening all patients over age 65 for atrial fibrillation. The risk of stroke was assessed and the need for anti-coagulants determined. The GP showed us a report of a medication review of patients on 12 or more medicines. As a result of the review the number of patients on 12 or more medicines was reduced from 25 to 18.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP and staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making

Management, monitoring and improving outcomes for people

The practice routinely gathered information about people's care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess performance and carried out regular clinical audit. The QOF is a national group of indicators, against which a practice scores points according to their level of achievement in the four domains of clinical, public health, quality and productivity and patient experience. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed 1.4 percentage points above the CCG average for patients with asthma, but 3.8 percentage points below the average for chronic obstructive pulmonary disease (COPD) and 19.7 percentage points below for diabetes. The GP was working to improve performance in the below average scores but had no formal action plan for this.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits undertaken in the last 12 months included audits of prescribing of silver dressings for wound care; prescribing of high dose inhaled corticosteroids (ICS) used for the long term control of asthma; patients with acute exacerbations of asthma and COPD; and cervical smears. We saw examples where action resulting from initial audits had been systematically monitored and reviewed further to test its effectiveness and complete the full clinical audit cycle. For example, an audit of patients with acute exacerbations of asthma and COPD completed in October 2013 identified 33 patients with acute exacerbations. An action plan was put in place to reduce exacerbations and the second cycle audit completed in December 2013 showed that the number had gone down to 10.

Effective staffing

The GP kept his skills up to date through regular training and continuing professional development. The GP had undertaken appraisals and was up to date with his revalidation. We saw the certificate for this.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. Appraisal reports had been completed for all but one recently appointed administrative staff for the current reporting year. The appraisal included the opportunity to discuss and agree their personal learning and development needs and they had continued to undertake relevant training throughout the year. The majority of staff we spoke with confirmed they had received an appraisal. However, no recent appraisals had been completed for nursing staff and the nurse we spoke with last had an appraisal four years ago.

There were arrangements in place for staff to receive mandatory training and additional learning and

Requires improvement

Are services effective?

(for example, treatment is effective)

development identified as part of the appraisal system. However, the mandatory training policy was a model policy and had not been tailored to the practice. We were provided with pre-inspection information about training completed by staff including child protection, first aid, medical emergencies and IT. However, there were some gaps in training administrative staff had received. For example, none had received fire safety training, and some had not been trained in basic life support. In addition, there was no documentary evidence of training completed by nursing staff and the nurse we spoke with had not received recent update training in several areas including the treatment of HIV, asthma, breast screening and cytology.

Staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to. The GP held quarterly practice meetings to discuss and review clinical and operational matters. We saw a sample of minutes of these meetings. There were also regular informal meetings to discuss ongoing issues, although these were not documented.

Working with colleagues and other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach to meet patients' needs and manage complex cases.

There was an effective system in place for arranging and reporting the results of blood tests, x-rays and smear tests for example. This included a timely follow-up system to ensure these had been seen by the GP on the same day and actioned. Results were usually received electronically. Nursing staff at the practice provided a phlebotomy service for blood tests. The majority of patients we spoke with were happy with how test results were reported to them.

The practice had out-of-hours (OOH) arrangements in place with an external provider. The OOH service shared information about any care provided to practice patients by fax with the practice the next day. This was reviewed by the GP in case further action was needed.

We were told patients were offered some choice about referrals for hospital appointments and community services. The practice used the national 'Choose and Book' service for referrals. The GP booked referrals through the service in the presence of patients after discussion of the options available. The majority of patients were referred to the the local acute hospital. Patients we spoke with who had been referred commented positively about the process.

The practice had an effective process in place to follow up patients discharged from hospital. Discharge summaries were received by fax and were followed up by the GP.

The GP met with district nurses, care co-ordinators and health visitors to help establish best care for patients with long term conditions. One patient we spoke with told us the doctor liaised with other professionals, the hospital and community services. The GP held peer review meetings at the practice with other GP providers to compare performance and develop best practice. For example, we saw the notes of a review of 20 patients' records to determine whether a follow up referral to the outpatients department was necessary.

The practice provided appropriate support to patients on the practice's end of life care register. At the time of the inspection there was only one patient on the register. The practice did not provide direct palliative care but worked in partnership with palliative care nurses and health visitors to ensure patients received appropriate support. The GP communicated with the out of hour's provider by fax to provide information about patients receiving end of life care.

The practice was part of a local pilot for the integration of health and social care for patients. The pilot was set up with the intention of improving care for people with diabetes and those over the age of 75 years. This involved attendance at monthly multidisciplinary group (MDG) review meetings with other GP services and a team of health and social care professionals. The MDG reviewed patients from the two groups registered with each practice to develop care planning and integrated care pathways.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local OOH provider to enable patient data to be shared in a secure and timely manner.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and

Requires improvement

Are services effective?

(for example, treatment is effective)

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

The practice had a consent policy which was understood and applied by staff. They confirmed they would always seek consent before giving any treatment and would make entries in patient records about consent decisions where appropriate. For some procedures such as minor surgery written consent would be obtained.

We found that clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. However, the practice recognised that this was an area for further development within the practice, especially in relation to understanding of capacity assessments and deprivation of liberty safeguards (DOLs). Clinical staff demonstrated an understanding of Gillick competencies when asked about seeking consent. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

There was a range of information available to patients in the waiting area which included leaflets which could be taken away from the practice. There was also helpful information on the practice website which provided links to the NHS Choices Website, and the most popular health subjects. There were specific sections on family health, long term conditions and minor illnesses.

The practice offered all patients in the 40-74 age group a health check. All newly registering patients were invited to a new registration consultation with the practice nurse to help identify and plan their medical needs. Patients with a learning disability were offered a physical health check.

The GP and nurses provided dietary advice and information for patients on healthy eating. Patients were referred to a dietician for additional support where appropriate.

The GP provided a smoking cessation advice service opportunistically during appointments.

The practice provided a family planning service, including fitting/removal of intrauterine contraceptive devices (IUCD) and birth control implants, and smear testing. The practice's performance for cervical smears was 76% in 2013/14.

The practice offered a full range of immunisations for children. Flu vaccination was offered to patients over the age of 65, those in at-risk groups (including patients with long-term conditions) and pregnant women. The practice also offered pneumococcal vaccinations to patients over age 65 and those at higher risk due to other illnesses and medical conditions. The practice offered a travel vaccination service.

The practice participated in a 2014/15, CCG commissioned direct enhanced service (DES) for dementia.

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 59 patients who responded to the national patient survey 2013/14 and a survey of 65 patients undertaken through the practice's patient participation group (PPG). The evidence from the national survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, in the national patient survey 85% of respondents rated the last GP they saw or spoke to as good at treating them with care and concern, and 92% the last nurse. Both of these ratings were above the CCG average. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them and 88% saying the GP gave them enough time.

In the PPG patient survey the practice scored 69% for respect shown, 68% for consideration and 64% for concern for the patient. These scores were below the average for other practices participating in the same survey. However, the views of patients we spoke with and those who completed CQC comment cards to tell us what they thought about the practice were more positive about these issues. We received 45 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent, professional service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with six patients on the day of our inspection including three members of the PPG. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They felt the practice really cared about them and their families.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. One patient commented that they did occasionally overhear patients' conversations at reception but this was because the patients themselves started talking about their conditions. Staff told us they would take patients to a private area if necessary to maintain confidentiality.

Patients we spoke with told us of specific support they had received for mental health issues and the diagnosis of long term conditions, including regular reviews and follow up appointments after hospital discharge. One mother we spoke with told us that staff knew their children and treated them with sensitivity.

We noted that staff had been appropriately briefed about the needs of particular patients. For example, reception staff were aware of the behavioural signs to watch for, for patients with poor mental health and how to respond to minimise avoidable distress during appointments.

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, data from the national patient survey showed 84% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area.

The results from the satisfaction survey conducted through the PPG were less positive and showed that the practice scored 65% for both 'explanations' and 'ability to listen'. These scores were below the averages for other practices participating in the same survey. However, 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 to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

The staff at the practice spoke many different languages which enabled them to communicate readily with most patients. However, if needed translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

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

The patients we spoke with were positive about the emotional support provided. Comments cards aligned with these views. One patient who commented told us they would not have got through a family health crisis without the support given by the GP.

The practice appropriately supported patients receiving end of life care. Bereavement advice was also available on the practice website.

Notices in the patient waiting room signposted patients to a number of support groups and organisations.

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 patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The majority of patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and in most respects they were happy with the service provided.

The practice ran ante-natal, post-natal and baby clinics.

The practice provided chronic disease management services for patients with diabetes, asthma, hypertension, coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Annual reviews including a medication review were carried out on all patients with long-term conditions in line with best practice guidance. Checks were also carried out opportunistically when patients attended for other reasons, for example blood tests.

The practice carried out spirometry tests to diagnose and monitor COPD and other lung conditions. The practice also had an ECG machine to enable clinical staff to carry out electrocardiogram tests to check patients with heart problems.

For older patients and patients with long term conditions home visits were available where needed and longer appointments were provided when needed.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, it had introduced an electronic prescription service and on line booking of appointments. New, more comfortable chairs had also been placed in the waiting area.

Feedback from the latest satisfaction survey conducted through the PPG showed that a number of patients would like a female GP at the practice. This view was also expressed in the comment cards we received. The practice's action plan in response to the survey included action to address this and the GP told us he was in the process of sourcing a suitable candidate to meet this need.

The practice participated in a number of enhanced services schemes including those for patients with dementia and learning disabilities and reducing avoidable unplanned admissions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was an open door policy and vulnerable groups such as the homeless and street sex workers could register, although none were on the practice's register at the time of the inspection.

The practice had access to an interpreter service and practice staff between them spoke 10 languages in addition to English.

The practice had an equal opportunities policy. Staff read the policy as part of the induction process and were aware of patients' equality and diversity needs covering a diverse population of patients. However, they had not received specific equality and diversity training.

The premises and services had been adapted to meet the needs of patients with disabilities. There was a ramp for wheelchair access and the toilet facilities had been modified to accommodate patients with a disability. However, there was no emergency pull cord provided.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

Access to the service

Appointments were available from 8.30am to 11.00am, Monday to Friday and 4.00pm to 7.00pm Monday, and 4.00pm to 6.30pm, Tuesday, Thursday and Friday; and 9.00am to 11.00am on Saturday. For emergency appointments, the reception liaised with the GP to triage the patient and these were accommodated on the same day or within 24 hours if less urgent. Feedback from the PPG indicated patients not able to attend surgery during normal surgery hours would like extended opening two evenings per week. The action plan from the PPG included consideration of moving the Monday evening clinic forward to 5-8pm and running a late evening surgery 5-8pm on Fridays. This had yet to be implemented, however.

Information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange home visits and how to book

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to those patients who needed one.

The GP provided a telephone advice service to patients between surgery hours to discuss test results. He was also available between 8.00am and 6.30pm to take calls for any patients with problems requiring urgent attention. The PPG action plan also included the introduction of on-line video consultations with the GP. This had yet to be implemented, however.

Patients we spoke with were generally satisfied with the appointments system. They confirmed that they could see the doctor on the same day if they needed to. They said that they were given the time needed when they saw the doctor or nurse, even if they had to wait beyond their appointment time. In the patient survey conducted through the PPG, the majority of scores for accessibility were above average compared to other practices participating in the same survey. However, they were below the average for speaking to the GP on the phone and waiting times for appointments. In the national patient survey, 54% of respondents said they usually waited 15 minutes or less after their appointment time to be seen. However, 98% of respondents described their experience of making an appointment as good, which was among the best in the CCG area (30% above the CCG average).

The practice's Saturday morning surgery was particularly useful to patients with work commitments. This was confirmed by in the patient survey conducted through the PPG.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was information on display in the waiting area about how to make a complaint. There was also a suggestion box in the waiting area where patients could make suggestions or comments which the practice reviewed regularly. There was also information about making complaints on the practice website. None of the patients we spoke with had needed to make a complaint about the practice.

We looked at the one formal written complaint received in the last 12 months and found that it had been dealt with appropriately and in accordance with the practice's complaints procedure. It had been responded to in a timely way and the complainant had been offered a further meeting to discuss the issues raised and clarify action taken, and was provided with information about organisations they could approach if they were dissatisfied with the outcome.

Staff we spoke with understood the complaints procedure and told us the GP would share any learning with them from complaints received. We were also told complaints were discussed at practice meetings. However, we did not see evidence of this in the minutes of meetings we reviewed and complaints were not a standing item on the agenda.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice vision, set out in its statement of purpose, was to work in partnership with its patients and staff to provide the best primary care services possible working within local and national governance, guidance and regulations. This was supported by a mission statement, "to improve the health, well-being and lives of those we care for." Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England. Not all staff we spoke with were aware of the statement of purpose document but they were able to articulate the essence of the mission statement and vision and it was clear that patients were at the heart of the service they provided. The practice promoted and valued continuity of care and patient feedback largely confirmed this

Governance arrangements

There were operational and clinical practice policies and procedures in place governing activity, including policies on consent, infection control and chaperoning. There was no formal review schedule for the practice's policies and procedures. They were, however, updated on an ad hoc basis to take account of new developments and changes. We noted that some policies were model policies obtained from external sources which needed further development to tailor them specifically to the practice in all aspects. These included the policies for mandatory training and infection control.

The practice had an informal management structure but it was led clearly by the GP and all staff had well defined roles which they knew and understood. All four staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. QOF data showed in the year ending April 2014 the practice performed about 10% below the average compared to other practices in the local CCG area in the clinical domain with a score of 83%. In other domains there was a more mixed picture where some indicators were above, the same or below the CCG average. The GP regularly reviewed and updated QOF data throughout the year but we did not see evidence that the data was discussed with the rest of the practice team at quarterly team meetings and there was no formal action plan in place to improve QOF scores.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Examples of clinical audits undertaken in the last 12 months included audits of prescribing of silver dressings for wound care; prescribing of high dose inhaled corticosteroids (ICS) used for the long term control of asthma; patients with acute exacerbations of asthma and chronic obstructive pulmonary disease (COPD; and cervical screening smears. Some actions for improvement had been identified as a result of the audits. For example, in the silver dressings audit, agreed action included was to ensure that all clinical staff at the practice adhered to the local wound care formulary (a process to support the management of dressings).

The practice had arrangements for identifying, recording and managing risks. The practice had a business continuity plan, to respond to and manage risks in the event of major disruption to the service. The practice also regularly monitored and reviewed risks to individual patients, using specific risk assessment and management tools where appropriate, and updated patient care plans accordingly. However, no health and safety or fire risk assessments had been completed in the practice to help ensure the safety and suitability of the premises.

Leadership, openness and transparency

We saw from minutes that formal team meetings were held, at least quarterly. Between these meetings the GP met informally with staff on an ongoing basis to discuss clinical and operational issues. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice had a range of human resource policies and procedures in place including, recruitment, grievance, bullying and harassment, equal opportunities and sick absence. However, electronic copies of these policies were held on the GP's computer and were not readily accessible to staff on the practice's computer system. At the

Are services well-led?

Requires improvement

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

inspection the GP undertook to make the policies available to all staff electronically. There was an employee handbook which included sections on conduct and discipline, equality and harassment and bullying at work.

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

The practice had gathered feedback from patients through patient surveys, comments placed in a suggestion box and complaints received. We looked at the results of the annual patient survey and saw that practice had developed action plans as a result of the feedback received. We reviewed a report on comments from patients conducted in January 2014, in which the appointment of a female GP had been requested to meet the personal beliefs of some patients. As a result the GP had initiated action to secure the appointment of a female GP.

The practice had an active patient participation group (PPG) which included representatives from a range of ethnicity and age groups. The PPG carried out annual surveys and met every quarter. The practice showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff generally through staff meetings, appraisals and day to day informal discussions. Staff told us their managers and the GP were approachable and they felt free to give feedback and discuss any concerns or issues with them.

The practice did not have a whistleblowing policy but we saw from practice meeting minutes the need for a policy had been recognised and the GP was committed to introducing this in the near future. Staff nevertheless knew who to approach if they had any concerns.

Management lead through learning and improvement

Administrative staff told us that the practice supported them to maintain and update their knowledge, skills and competence through training. We looked at staff records and saw that they received regular appraisals which included a learning and development plan. Nursing staff felt supported by the GP but had not received refresher training in a number of areas or had a recent appraisal.

The practice had completed reviews of significant events and other incidents which included lessons learned. There were no particular themes in the three significant events reviewed in the last year. We were told that any significant events would be discussed at practice meetings. However, such events were not a permanent item on the agenda of the formal meetings and we did not see any recorded evidence of these discussions.

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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The provider did not always take proper steps to protect patients against the risk of receiving inappropriate or unsafe care because there were insufficient procedures in place for dealing with medical emergencies and published guidance had not been adequately followed. Regulation 9 (1) (b) (ii) and (iii) and (2).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: Patients and others were not protected against the risks associated with infection because of shortfalls in the operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections. Regulation 12 (1) and (2) (a).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met:

This section is primarily information for the provider

Compliance actions

Patients and others were not protected sufficiently against the risks associated with unsafe or unsuitable premises because appropriate risk assessments related to the operation of the premises had not been carried out.

Regulation 15 (1) (c).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: Patients were not fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post. Regulation 21 (a) and (b).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The provider did not have adequate arrangements in place to support staff in relation to their duties and responsibilities because there were gaps in training and appraisal of staff. Regulation 23 (1) (a).