Dr Gul Mohammad Khan

Quality Report

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Date of inspection visit: 10 June 2015
Date of publication: 13/08/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the practice of Dr Gul Mohammad Khan on 10 June 2015. 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 was good for providing caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Although some audits had been carried out, these were single cycle audits and we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. Routine appointments could be made several weeks in advance.
- The practice staff met informally every day. More formal meetings were held monthly and brief minutes were kept.
- The GP had sought feedback from patients as part of their appraisal process.
- All staff at the practice spoke more than one language to meet the needs of the practice population.

The areas where the provider must make improvements are:

- Ensure young people under 16 who have the legal capacity to consent are treated with dignity and privacy and given independence. These young people must be treated with consideration and respect.

Summary of findings

- Ensure consent is gained from the relevant person prior to care or treatment taking place. If a person over the age of 16 is unable to give such consent because they lack capacity to do so, the provider must act in accordance with the Mental Capacity Act 2005.
- Ensure all staff have completed mandatory training such as fire safety training and basic life support, and that this training is updated regularly.
- Ensure standards for the cleaning of the practice are set out and adhered to, including identifying cleaning tasks that should be carried out daily. Staff, including the infection control lead, must be trained in the prevention and control of infection.
- Ensure all staff have received training in safeguarding children and vulnerable adults to the appropriate level and that this training is updated at appropriate intervals.
- Ensure there are systems in place to regularly monitor and assess aspects of the practice. This includes completing full clinical audit cycles and performing regular checks to ensure all medicines and equipment are within their expiry dates.
- Ensure that recruitment procedures are in place so that only suitable people are employed. Ensure required information, such as a full work history and identification is kept for all staff and all relevant pre-employment checks are carried out.

In addition the provider should:

- Set up a register so all patients with a learning disability can be identified.
- Formalise meetings in order to evidence information such as significant events have been discussed with all relevant staff.
- Improve the business continuity plan so it includes accurate information about the action to take in the event of an emergency.
- Provide the practice manager with the support and training they require.

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 as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learned were communicated with staff.

Safeguarding training for the GP was out of date. Staff had not been trained in infection control and the practice was cleaned once a week by staff members. A Disclosure and Barring Service (DBS) check had not been carried out for all appropriate staff. Not all staff had received fire awareness training. Systems were not in place to ensure medicines and equipment were within their expiry dates.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. The GP accessed new guidance and sought advice from the clinical commissioning group (CCG) when needed. There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. The GP did not have an understanding of the Gillick Competencies and would not see patients under the age of 16 without an adult present. They did not have an understanding of the Mental Capacity Act 2005.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with other for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with the

Summary of findings

GP, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available although no formal complaints had been made for over five years.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. Although the small staff team worked closely together and met informally on a daily basis there was no formal strategy or vision in place. There was one GP who was approaching retirement but there had been no succession planning. It had a vision and a strategy but not all staff was aware of this and their responsibilities in relation to it. Reception staff felt well-supported but the practice manager did not have appraisals and accessed limited training. There was no patient participation group (PPG).

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 for the care of older people. The provider was rated as requires improvement for providing safe, effective and well-led care and the concerns that led to these ratings apply to everyone in the practice, including this population group. Older people with a higher risk of an unplanned hospital admission did not have care plans in place. The practice manager told us they had not needed to provide end of life care since 2012 so did not have any patients on a palliative care register. Home visits were made to patients when they were requested. The practice manager told us they had no housebound patients.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider was rated as requires improvement for providing safe, effective and well-led care and the concerns that led to these ratings apply to everyone in the practice, including this population group. Patients with a long term condition had an annual review with the GP. If they had a higher risk of an unplanned hospital admission care plans were not in place.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as requires improvement for providing safe, effective and well-led care and the concerns that led to these ratings apply to everyone in the practice, including this population group. The provider was a single-handed male GP. Female patients were referred to another clinic when it was thought an intimate examination may be required. The GP did not see children under the age of 16 without an adult being present and they were not familiar with the Gillick competencies. Not all staff had received training in safeguarding children.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The provider was rated as requires improvement for providing safe, effective and well-led care and the concerns that led to these ratings apply to everyone in the practice, including this population group. Extended hours opening was available twice a week and patients

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could book appointments several weeks in advance to fit in with other commitments. Appointments could be booked on-line and prescriptions could also be ordered this way. Health promotion advice, including travel health, was available.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as requires improvement for providing safe, effective and well-led care and the concerns that led to these ratings apply to everyone in the practice, including this population group. The practice did not have a register of patients with a learning disability. Training in safeguarding vulnerable adults had not been provided for all staff. The GP was not familiar with the requirements of the Mental Capacity Act 2005 and did not obtain consent in the correct manner.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as requires improvement for providing safe, effective and well-led care and the concerns that led to these ratings apply to everyone in the practice, including this population group. Patients with mental health needs had a regular review with the GP. There were no enhanced services around dementia care. The GP provided counselling service for some patients and patients were referred to local services if this was more appropriate.

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What people who use the service say

During our inspection we spoke with six patients. We reviewed 10 CQC comments cards that had been completed by patients prior to the inspection.

All the patients we spoke with and comments cards we reviewed gave us positive feedback about the practice. They told us that appointments were usually available on the day they requested one and they could book routine appointments several weeks in advance. They told us they thought highly of the GP and reception staff were friendly and treated them respectfully. They also commented that the practice was clean and hygienic. Female patients told us they felt comfortable seeing the male GP for most issues. They told us they were referred to a nearby clinic if they wanted to see a female GP, and one patient told us they had been to the walk in centre on one occasion as a female GP was available there.

The friends and family test showed that the majority of patients would be extremely likely to recommend the practice.

We looked at the results of the latest national GP survey. This highlighted what the practice did best:

- 85% of respondents usually wait 15 minutes or less after their appointment time to be seen. (Clinical Commissioning Group (CCG) average 57%)
- 96% of respondents find it easy to get through to this surgery by phone. (CCG average 73%)
- 89% of respondents describe their experience of making an appointment as good. (CCG average 71%)

Less positive results were:

- 78% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments. (CCG average 84%).
- 75% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care. (CCG average 79%).
- 69% of respondents would recommend this surgery to someone new to the area (CCG average 72%).

The less positive results were not reflective of the patients' comments we received during the inspection process. The practice manager told us they thought in some cases patients' children had completed the questionnaires and the results may not be completely accurate.

Areas for improvement

Action the service MUST take to improve

- Ensure young people under 16 who have the legal capacity to consent are treated with dignity and privacy and given independence. These young people must be treated with consideration and respect.
- Ensure consent is gained from the relevant person prior to care or treatment taking place. If a person over the age of 16 is unable to give such consent because they lack capacity to do so, the provider must act in accordance with the Mental Capacity Act 2005.
- Ensure all staff have completed mandatory training such as fire safety training and basic life support, and that this training is updated regularly.
- Ensure standards for the cleaning of the practice are set out and adhered to, including identifying cleaning tasks that should be carried out daily. Staff, including the infection control lead, must be trained in the prevention and control of infection.
- Ensure all staff have received training in safeguarding children and vulnerable adults to the appropriate level and that this training is updated at appropriate intervals.
- Ensure there are systems in place to regularly monitor and assess aspects of the practice. This includes completing full clinical audit cycles and performing regular checks to ensure all medicines and equipment are within their expiry dates.

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- Ensure that recruitment procedures are in place so that only suitable people are employed. Ensure required information, such as a full work history and identification is kept for all staff and all relevant pre-employment checks are carried out.

Action the service SHOULD take to improve

- Set up a register so all patients with a learning disability can be identified.
- Formalise meetings in order to evidence information such as significant events have been discussed with all relevant staff.
- Improve the business continuity plan so it includes accurate information about the action to take in the event of an emergency.
- Provide the practice manager with the support and training they require.

Dr Gul Mohammad Khan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and also included a GP specialist advisor.

Background to Dr Gul Mohammad Khan

The practice of Dr Gul Mohammad Khan is also known as Aleeshan Medical Centre. The practice is located in an end terraced house in a residential area of Cheetham Hill, Manchester. The ground floor of the practice has been extended and is accessible to patients. The first floor is used by staff only. The building and consulting room are accessible to patients with mobility difficulties.

The practice is in an area where there are high levels of deprivation. There is a much lower than average number of patients over the age of 60 and a higher than average number of young patients under the age of 19.

The practice is run by a single handed male GP supported by a practice manager and three reception staff. There is no practice nurse.

The GP has worked at the practice since 1992 when it was a partnership with 4000 patients. When they became a single handed practice they decided how many patients to keep on the list and decided which patients to invite to stay with the GP.

The practice is open from Monday to Friday 8am until 6.30pm. Appointments with the GP are between 9am and 11am, and then between 4pm and 6pm. Each Monday and Thursday evening there is extended hours opening until 7pm. The practice is closed each Wednesday afternoon.

Dr Gul Mohammad Khan had opted out of providing out of hours services to their patients. This service was provided by a registered out of hours provider, who also provided a service on Wednesday afternoons.

The practice provides commissioned services under a General Medical Services (GMS) contract to approximately 1300 patients.

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.

How we carried out this inspection

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

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

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

- Older people

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 June 2015. During our visit we spoke with the GP, practice manager and receptionist. We also spoke with six patients and reviewed 10 CQC comments cards.

Requires improvement

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and North Manchester Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

The practice held an incident book but had not had reason to use it. We saw that relevant forms were completed following the occurrence of significant events. The Practice manager then assessed the forms and determined what action to take. Staff told us that meetings were held after the occurrence of significant events and these were separate from other practice meetings. Due to the practice being small staff were able to arrange informal meetings at short notice. The staff we spoke with were aware of how to report significant events, and usually reported them to the practice manager in the first instance.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred. Staff told us that national patient safety alerts and significant events were regularly discussed, mainly during informal discussions. Learning was also discussed. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We saw an example of changes to practice being made following a significant event. This involved the GP directing the majority of female patients presenting with particular symptoms to have blood tests.

Only one GP worked at the practice. They usually received safety alerts but there were no other clinical staff at the practice to share clinical issues with. The GP said that they received help from the practice manager or administrative staff on occasions when alerts were received.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Policies were in place that provided staff with relevant information. The practice also held information from Manchester City Council about adult and children's safeguarding.

The GP was the lead for safeguarding. They had received training to level 3 in October 2011. We also saw they had received training in child sexual exploitation in January 2013. We saw evidence that two of the three reception staff had completed e-learning in safeguarding adults and children in 2015. One staff member, who had worked at the practice for over two years, had not received training. The practice manager told us that this was due to them starting work after the formal training had been provided. The practice manager said they would arrange for them to complete training at a convenient time.

We asked all the staff we spoke with about their understanding of safeguarding. They all knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. The GP told us they had not made any safeguarding referrals during the previous 12 months, and they had no looked after children or children on the child protection register. They had system in place to manage these if they occurred.

Patient appointments were conducted in the privacy of an individual consulting room. Reception staff were occasionally asked to chaperone a patient during an examination. Although they had not received formal training the GP had explained their role which they understood. A chaperone policy was in place, dated February 2015, but this did not include instructions such as where the chaperone should stand during an examination. A Disclosure and Barring Service (DBS) check had not been carried out for all staff who acted as a chaperone, and the practice had identified that all staff at the practice should have a DBS check. The practice manager told us they had decided that all staff performing chaperone duties should have a DBS check but they had not yet received all the necessary identification documents from staff to enable them to apply for them.

Medicines management

Requires improvement

Are services safe?

We checked the medicines stored in the treatment rooms and medicine fridge. These included vaccines that needed to be stored within a specific temperature range. All medicines were securely stored and all within their expiry date. Appropriate medicines were held for use in an emergency. We saw that these medicines were also within their expiry date. The GP told us that the practice manager regularly checked the medicines were available and in-date. The practice manager told us they occasionally carried out random checks of medicine expiry dates. However, there was not a system in place to carry out these checks and no record of the checks was kept. The GP said they never took medicines on home visits.

The temperature of the medicines fridges was monitored on a daily basis. A record was kept of these checks. Staff shared this duty with the first staff member who arrived in the morning and the last leaving at night performing the checks. There were two fridges on the premises. One was in use and one was kept as a back-up in case of emergencies. Staff knew what action to take if the temperature was outside the required range.

We saw that prescriptions were kept locked in a safe away from patient access. The GP said they never took blank prescriptions off the premises; if a prescription was required on a home visit this was arranged via the local pharmacy.

Repeat prescriptions could be ordered on-line, in person or in writing. Although the practice advertised a 48 hour turnaround time staff told us requests were usually dealt with within a few hours.

Cleanliness and infection control

During our inspection we found the premises to be visibly clean and uncluttered. Patients told us that they always found the practice clean. Liquid soap, hand gel and paper towels were next to all hand wash basins and the GP's surgery contained a supply of disposable gloves. The examination couch in the surgery was in good condition. There was a privacy screen and this appeared clean.

There was an infection control policy in place dated 4 February 2015. This stated that all staff would have training in infection control, including hand washing, on an annual basis. The practice manager told us no staff member had been trained and the staff we spoke with confirmed this. The practice manager had the role of lead for infection control, but had not been trained in this role. There were other policies in place relating to the prevention and control of infection, and these included the disposal of clinical waste.

The practice manager told us staff had joint responsibility for keeping the practice clean. All staff, including the GP, cleaned the practice each Friday. There was a cleaning schedule that gave weekly, monthly, and less frequent tasks. There were no daily cleaning tasks noted. We saw there was a cleaning record completed each week with brief information, for example "all rooms cleaned" and "floors cleaned". Staff told us they used disinfectant wipes to clean surfaces, sinks and the immunisation tray. They said that although cleaning took place weekly they kept an eye on the practice and would clean in-between when necessary. There was a spillage kit with instructions kept in the practice. The practice manager told us they did not monitor the quality of cleaning and they tried their best to adhere to the cleaning schedule.

There was a bath in an upstairs room that was never used. The practice manager told us they cleaned this twice a week due to the risk of Legionella (a germ found in the environment which can contaminate water systems in buildings). However, the GP told us there was no risk of Legionella as they no longer had a water tank. A Legionella risk assessment had not been carried out.

We saw that an infection control audit had been carried out in 2011 by the Primary Care Trust (PCT). The practice manager told us they now carried out minor annual audits. The infection control policy stated that random and unannounced infection control inspections would be carried out by the GP and practice manager bi-yearly. We saw a hand hygiene review had been carried out in December 2014. This stated staff had received guidance in hand washing. The practice manager told us that other information had been held but these had gone missing when their computer system changed.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that portable electrical equipment had last been tested in August 2012. We saw evidence of calibration of relevant equipment, for example medical scales, the blood pressure monitor, vaccine fridge and pulse oximeter had been carried out in January 2015.

Requires improvement

Are services safe?

Staffing and recruitment

The practice had a recruitment policy in place but this was not dated. This was a very brief document that did not clearly set out the process to be followed when recruiting new staff. It stated that a Disclosure and Barring Service (DBS) check would be carried out for all staff. It stated that in theory references would be sought, including from the most recent employer, but other checks were not mentioned.

We looked at the available personnel files. These were for the three reception staff. The practice manager told us they did not have a personnel file for themselves and no information had been kept for them. We saw that although the practice had decided DBS checks were appropriate for all staff they had only been obtained for two reception staff. There was no check for the remaining receptionist or the practice manager. Following our inspection the practice manager sent us confirmation that a DBS check had been returned for the receptionist on 22 June 2015. Identification was held for the three reception staff but not for the practice manager. The reception staff had provided a curriculum vitae but this did not always include a full work history and gaps in employment had not been queried.

The GP worked alone and had two surgery sessions each day except Wednesday, when they held one session in the morning. They told us they did not have time off and did not have holidays. They had an arrangement with a nearby practice so that in an emergency one of their GPs would provide cover until a locum GP could be sourced. There was a locum policy in place and the practice manager told us they would use a locum agency if required, although the need had not arisen. A registered out of hours provider provided cover when the practice was closed, including on Wednesday afternoons.

There was no practice nurse. The GP told us they had a nurse until approximately two years ago and they felt they could deliver their service without a nurse. The reception staff were very flexible and cover was always available if they needed time off.

Monitoring safety and responding to risk

The practice manager told us they carried out regular informal checks of the building but these were not recorded. Any issues found were said to be dealt with immediately but these were not fully recorded and so could not be evidenced. Monthly checks of the fire alarm, smoke alarm and emergency lighting were recorded. Access to the building was via the back of the practice. Patients pressed a buzzer to gain access and a receptionist could see who was at the door on a CCTV monitor.

Although all the medicines we checked were within their expiry date there was no system of checking medicines to ensure the required medicines were available and ready for use. The practice manager told us they regularly checked the oxygen was ready for use but did not record this either.

The staff worked closely together and met regularly to talk about aspects of the practice. The staff we spoke with told us aspects of safety were discussed frequently and they were kept up to date with safety. However, meeting minutes were brief and no evidence was seen of these specific discussions.

Arrangements to deal with emergencies and major incidents

The practice had a disaster handling and business continuity plan in place dated January 2015. This was available in the surgery and was also kept at the homes of the GP and practice manager. Although this gave information about the procedure to follow in the event of utilities such as electricity or water being unavailable, it did not detail relevant contact numbers that may be required in an emergency. The plan did not include what procedure to follow if the building could not be accessed. It mentioned the action to take if one of the partners was incapacitated, stating the remaining partners would cover their work. However, the provider was an individual GP and there were no partners. Following the inspection the practice manager provided us with evidence of an agreement between the GP and GPs from another practice who would provide cover in an emergency.

Staff, including the GP, had been trained in basic life support in March 2013. There was no plan in place to update this training. Oxygen was held at the practice and there was a sign on the outside of the GP's surgery to alert people it was stored there. The practice manager told us they carried out checks on the oxygen but did not record these. We saw the oxygen was ready for use and adult and paediatric masks were available. There was no automatic external defibrillator at the practice. The practice manager told us if would be their policy to dial 999 in the event of an emergency and the nearest Accident and Emergency department was 1.2 miles away.

Requires improvement

Are services safe?

Emergency medicines were kept in a locked cupboard in the GP's surgery. The medicines kept were appropriate and all within their expiry date. The GP told us the practice manager checked these medicines but the practice manager was unaware of these checks. We saw an anaphylaxis kit kept in a room that had been used by the nurse when one was employed. This kit contained syringes with an expiry date of 2010.

The practice had carried out a fire risk assessment in May 2012. We saw that following this assessment the necessary improvements were put in place by the end of July 2012.

No further risk assessment had been carried out. We saw evidence that the fire alarms and smoke alarms were tested each month. We saw evidence that the GP, practice manager and two receptionists had completed fire awareness training in August 2012. The remaining receptionist had never had fire awareness training as they were on leave when it took place. They said that their colleagues gave them the relevant information. No updated training had taken place. Fire extinguishers had been serviced in April 2015.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP 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.

We discussed with the practice manager and GP how NICE guidance was received into the practice. The GP downloaded guidance from the website. As no other clinicians worked at the practice there was no dissemination process. If there was any guidance that staff needed to know about the GP discussed this during the informal meetings. Staff confirmed this happened although a record was not kept. The GP demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

The GP described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The GP read coded major conditions only. They told us they knew their patients well and recorded information about patients' conditions on the electronic patient notes. They received an alert when a patient required an annual review of their condition. However, they said they carried out a lot of reviews on an opportunistic basis when patients attended for other matters.

The GP held dedicated clinics for conditions such as diabetes and asthma, and they also held weekly baby clinics. Although they worked alone they attended monthly clinical commissioning group (CCG) meetings to help them keep up to date with the latest guidance. They also met regularly with a local GP so specific cases could be discussed.

The GP at the practice was male and there was no practice nurse. Female patients were usually referred to a nearby clinic or family planning clinic if an intimate examination was required. The female patients we spoke with told us this did not cause a problem as they knew when they registered that there was no female clinician at the practice.

Discrimination was avoided where possible when making care and treatment decisions. The GP explained that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. However, female patients were often referred to a nearby clinic if it was thought an intimate examination was necessary.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

We saw that the GP had completed some audits but there had been no audit cycles completed. The GP told us they had never been asked to complete re-audits. Two diabetic audits had been completed, but there was no evidence of information being used to improve outcomes for patients. Other audits related to reducing Accident and Emergency attendances and emergency hospital admissions, and the benefits of keeping an electronic death register.

The GP told us they did not have care plans in place for high risk patients with a view to reducing hospital admissions. They said they had very few high risk patients.

The prevalence of chronic obstructive pulmonary disease (COPD) for patients of the practice was lower than expected. The GP explained that this was a coding issue. They now looked at the age and smoking status of patients and invited them to attend for a check if they were at risk. Patients with mental health issues had a review of their condition every six months. The GP said they were often able to perform these checks opportunistically, and they always carried out any other checks required at the same time. The GP also carried out annual reviews for patients with long term conditions. These were either in the dedicated clinics they held or on an opportunistic basis.

The GP carried out medicine reviews for patients on a regular basis. They kept up to date with new guidelines and changed patients' medicines when they felt this was appropriate. They had an electronic system in place to alert them if a patient required a medicines review. The GP told us they did not proactively visit housebound patients but they would visit patients who requested a home visit.

Requires improvement

Are services effective?

(for example, treatment is effective)

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Effective staffing

The practice was very small and the practice team included one GP, a practice manager and three reception staff. The practice manager told us that staff were enthusiastic and asked for training they felt would be beneficial. There was no protected learning time but staff were given log-in details so e-learning courses could be accessed from their homes.

There was no system in place to monitor training completed and training where updates were required. We saw that not all staff had completed mandatory training such as fire safety training and safeguarding. Infection control training had not been provided for staff. However, one member of staff had asked to have training in customer relations and this had been arranged.

We saw evidence that the GP had had an appraisal each year for the past 10 years. They had been revalidated in May 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Reception staff had an annual appraisal with the practice manager. We saw that these had been carried out in November 2014 and a personal development plan (PDP) had also been put in place. The PDPs did not highlight when mandatory training should be reviewed.

The practice manager did not have a personnel file but training certificates were held for some training. They did not have appraisals. They told us that it was difficult for them to go on training courses as they could not be away from the practice for long.

Working with colleagues and other services

The practice worked with some other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. Most hospital correspondence was received electronically and it was reviewed by the GP prior to being filed.

The practice had contact numbers for district nurses in the area. Patients were referred to district nurses when this was required. The practice manager told us they used to arrange multi-disciplinary team (MDT) meeting for patients with complex needs but the nurses in the area no longer had the time to do this. The GP also had an arrangement with another clinic in the area that would see female patients requiring intimate examinations. The GP did not carry out smear tests but patients told us they did stress the importance of having these regular checks and they were directed to a local family planning clinic.

The GP was aware of the system of informing the out of hours provider of patients receiving end of life care. However, they said they had no-one on the palliative care register. They told us they last had a patient requiring end of life care in 2012 and there had been no unexpected deaths since then. They had a young practice population.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services, although this had not been required. .

The practice had systems to provide staff with the information they needed. The GP used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. Due to the very small practice population we were told that there was little need to share information with others.

Consent to care and treatment

We asked the GP and practice manager about their policy regarding patients under the age of 16 attending for appointments. The GP told us they would not see a patient under the age of 16 unless they had an adult with them. The practice manager confirmed this and added that they would challenge a patient if they appeared to be under the age of 16. They told us that if they attended alone they

Requires improvement

Are services effective?

(for example, treatment is effective)

would not be seen, but if a patient under the age of 16 did get through to see the GP they would ensure a chaperone was present. We asked the GP about assessing Gillick competencies. Gillick competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. They told us they did not know how to assess Gillick competencies.

We asked the GP how they managed consent for specific patients, for example those with learning disabilities. They told us that if a patient had a learning disability they would ask their carer to consent. A knowledge of assessing the capacity of patients under the Mental Capacity Act 2005 was not demonstrated. The practice manager told us training in the Mental Capacity Act 2005 had not been carried out but they were looking at providing it. However, following the inspection they provided evidence that the GP had received the training in May 2014.

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

The latest national GP patient survey reflected that 78% of respondents said the GP was good at explaining tests or treatments to them (CCG average 84%). Also 75% of respondents said the GP was good at involving them in decisions about their care (CCG average 79%).

Health promotion and prevention

We saw that new patients registering with the practice completed all the necessary forms, including a health questionnaire. When a patient registered they were booked in for a new patient appointment with the GP. This was for a general health check, and patients were also referred to a local hospital so blood tests could be carried out, primarily to check for diabetes.

NHS Health Checks for patients aged over 40 or over 75 were being carried out by the GP. They said they had been carrying out these checks for several years, but data was not kept about how many patients had attended for these checks.

The practice had a system in place to ensure patients eligible for the flu vaccine received these. The practice manager told us their patients knew the system for receiving a flu vaccination and made appointments. They also have the vaccination opportunistically if an eligible patient attended the practice for any other reason. We saw the practice had a high rate of childhood vaccinations. If patients did not attend for vaccinations staff would telephone them.

The GP provided smoking cessation advice to patients and could also refer to a nearby clinic. The GP also provided counselling, including bereavement counselling, to patients. There was a local counselling service they could be referred to if necessary. The GP provided a travel vaccination service. During 2014 the GP had worked in partnership with a local mosque to provide diabetic awareness for those following a Halal diet.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent national GP patients' survey results. The patient survey showed that 84% of patients thought their GP was good at treating them with care and concern (Clinical Commissioning Group (CCG) average 83%) and 85% thought their GP was good at listening to them (CCG average 86%). The survey showed that 97% of patients found the receptionists helpful (CCG average 86%) and 85% thought the GP gave them enough time (CCG average 84%).

The patients we spoke with gave us extremely positive comments about the staff at the practice. They told us staff were friendly and always treated them in a respectful manner. We reviewed 10 CQC patient comments cards, and these gave us no concerns about the respect, dignity and compassion provided by the practice. Patients stated staff were very caring, the receptionists were helpful and the GP listened to them.

Patients told us they had enough privacy at the reception desk. We did not see more than one person in the waiting room at any one time as there was only one GP for appointments. There were private rooms available if a patient requested a more private conversation. There was also a privacy room available with a sign outside indicating the room could be used by mothers who wished to breastfeed their children.

There was only one GP at the practice and they were male. Female patients told us they did not find this to be an issue. They were aware there was no female GP and they accepted they would have to go to a nearby clinic for some consultations and examinations. One patient told us they went to the walk in centre at times if they wanted to see a female GP.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. A curtain was provided around the examination couch. We noted that the consultation room door was closed during consultations and that conversations taking place in this room could not be overheard.

Care planning and involvement in decisions about care and treatment

The latest national GP patient survey information showed 75% of patients felt the GP was involving them in decisions about their care (CCG average 75%). The survey showed that 78% of patients thought the GP was good at explaining tests and treatment (CCG average 84%). The patients we spoke with told us the GP always explained things to them in a way they understood. Some of the CQC comments cards we reviewed also mentioned that the GP explained things to patients, with no concerns being highlighted.

Staff told us that translation services were available for patients who did not have English as a first language. Face to face or telephone interpreters were accessed. The website could also be translated into different languages.

We saw that a range of information about various medical conditions was available in the reception area. Information about other services that were available in the area was also displayed.

Patient/carer support to cope emotionally with care and treatment

The GP told us they provided a counselling service to patients and this included bereavement counselling if needed. However, they also made referral to a local counselling service if they felt this was more appropriate. The patients we spoke with told us they had not required emotional support from the GP. However, they said the GP and all the staff were very easy to get along with and they felt able to speak to them about any matter.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. The GP received alerts when these reviews were due, and they also gave opportunistic reviews if patients attended the practice for other matters. When patients with mental health needs attended for their annual review other opportunistic checks, such as blood pressure or flu vaccinations, were carried out. Medicine reviews were arranged at appropriate intervals for patients who required regular medicines. The practice did not hold a register of patients with a learning disability. The GP said they knew their patients well and this was not required.

The GP attended monthly meetings at the clinical commissioning group (CCG), and also locality meetings with other GPs in the area. These gave them the opportunity to find out how other practices met the needs of their patients. They did not have any multi-disciplinary meetings due to the availability of district nurses in the area. The GP told us that if they needed a gold standard framework meeting for a patient requiring palliative care this would be arranged. However, they said this had not been needed since 2012.

The practice did not keep information about the prevalence of disease. The GP told us that there was a very small patient population of 1300 and they knew the patients well. This had the advantage that they could identify changes in patients' conditions and recognise when their needs changed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They told us that up to 90% of patients spoke limited English and approximately 30% did not speak English at all. The GP spoke several languages and all the other staff spoke at least one language other than English. The practice was able to access a telephone translation service. However, they said this had not been required due to the languages spoken by the GP. The practice used an on-line translation service of written records that needed translating. The website also had access to fact sheets in several languages.

The practice did not have any homeless patients. They told us that although an address is usually required for a patient to register they would seek advice from the CCG about how to register a homeless person should the need arise. There were no travellers in the immediate vicinity.

Housebound patients were not coded on the computer system but the GP and practice manager told us they knew who their housebound patients were. Home visits were made when appointments were requested.

The practice was in a converted two storey terraced house. The ground floor was for patients' use and the first floor was office space, a staff kitchen and a staff bathroom. The ground floor was fully accessible for patients with a disability or using a pushchair. There was a dedicated disabled parking space on the drive of the property. The practice had a hearing loop for patients who were hard of hearing. There was an accessible toilet.

Access to the service

The practice was open from Monday to Friday 8am until 6.30pm. Appointments with the GP were between 9am and 11am, and then between 4pm and 6pm. Each Monday and Thursday evening there was extended hours opening until 7pm. The practice was closed each Wednesday afternoon. The out of hours service was available when the practice was closed.

The GP and practice manager told us that patients were usually able to access an appointment the day they contacted the practice. Patients were sometimes given an appointment for the following day. If the appointments for the day were taken and a patient telephoned to say they needed urgent medical attention the GP would speak to the patient by telephone. They said they would always give a patient an appointment where there was an urgent need. The practice did not monitor the availability of appointments as they said there had never been any issues regarding access to the service.

In-between the morning and afternoon surgeries the GP held clinics, such as for asthma, chronic obstructive pulmonary disease (COPD) and travel vaccinations. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice manager told us they had a very low rate of patients not attending appointments, and if they failed to attend two appointments they would telephone the patient to see if they had difficulties attending.

Appointments could be booked on-line, by telephone or in person. Although appointments were usually available the same day the patients could make an appointment as far in advance as they wished. The practice manager told us this was rarely an issue to the high attendance rates.

The responses to the most recent national GP patient survey showed higher than average responses to questions relating to appointments. We saw that 96% of patients said their last appointment was convenient (CCG average 90%) and 96% said they found it easy to get through to the practice on the telephone (CCG average 73%). In addition 89% of patients rated their experience of making an appointment as good (CCG average 71%) and 79% of patients said they were satisfied with the opening hours (CCG average 76%).

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.

There was a complaints policy in place dated January 2015. This gave comprehensive guidance about how complaints should be handled. It stated that where complaints were made verbally they would also be recorded. The staff we spoke with told us they were familiar with the action they should take if a patient made a complaint, except that they told us they would try to rectify verbal complaints at the time they were made and not record them.

Although there was a process in place the practice told us the last complaint made to them was over five years ago. However, as verbal complaints were not recorded this information could have been inaccurate. Patients told us they would feel able to approach the practice if they were unhappy with any issue.

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 had one GP, a practice manager and three reception staff. The team worked and communicated well together but there was no strategy or vision in place. The staff we spoke with told us they always did what they could for their patients and although there was no practice vision in place they tried to provide high quality easy to access care.

The GP was approaching retirement but succession planning had not taken place.

Governance arrangements

Areas of responsibility and accountability for all staff were clearly defined. The small staff team met informally daily so were kept up to date with all appropriate issues. Some more formal meetings took place and brief minutes were kept of these.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing below national standards. The practice manager explained that they were unable to carry out some QOF tasks due to there being only one GP, and other than childhood vaccinations they did not offer any other enhanced services. However, they also said they had been carrying out health checks for the over 40s for several years but had been unaware they could be claimed for.

The GP told us they monitored the quality of the service they provided by carrying out audits, but we did not see evidence of this. They also said they used their annual appraisals as a way of monitoring quality.

Leadership, openness and transparency

The practice manager took the lead for quality in the practice. The GP, practice manager and reception staff worked closely together and met informally each day. They all understood their role in contributing to providing a quality service.

Reception staff told us that they felt valued, well supported and able to approach the practice manager of GP if they had any concerns.

The practice manager told us they tried to have a formal monthly meeting for all staff. Brief minutes were kept. They said they circulated the minutes to any staff who could not attend, but because they had a small staff team it was easy to discuss issues directly with staff.

Seeking and acting on feedback from patients, public and staff

The practice manager told us they had previously had a patient participation group (PPG) but all the information from this had been lost when their computer system changed. They no longer had a PPG but said they knew they would need to put one in place next year as part of their contract with NHS England.

There was a suggestion box in the waiting area of the practice. The practice manager told us this was rarely used and they had no records of previous suggestions made. However, they told us that patients had previously requested a weighing machine and a blood pressure monitor in the waiting room and they had been able to provide this.

The practice encouraged patients to take part in the NHS Friends and Family Test, and they were able to do this either on-line or at the practice. We saw the results to date were mainly positive.

As part of their appraisals the GP commissioned a patient survey about their service. The last one was carried out in January 2013 and we saw the results and comments were very positive. They told us they did look at the national patient survey results and they had informal chats with patients to ask their opinion at times.

Management lead through learning and improvement

Staff told us they thought they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. However, their personnel records showed that not all appropriate training had been carried out or was up to date. The GP was proactive in accessing training, mainly on-line. They were able to supply us with a list of the clinical training they had completed during the previous two years. Reception staff had a personal development plan in place and we saw they discussed their development with the practice manager. The practice manager did not have appraisals and had accessed limited training.

Are services well-led?

Requires improvement

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

The GP obtained the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), indicated that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found that the registered person did not treat all their patients with dignity and respect. They did not ensure the privacy of all patients. This was in breach of regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met:** The provider was unwilling to see patients under the age of 16 without an adult being present. They were unaware of the Gillick Competencies. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person did not always obtain consent from the relevant person. Where a patient over the age of 16 did not have the capacity to consent the provider did not act in accordance with the Mental Capacity Act 2005. This was in breach of regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** Where a patient did not have the capacity to consent the provider routinely asked other people to consent on their behalf and did not carry out an assessment according to the Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person did not ensure care and treatment was always provided in a safe way by doing all that was reasonably practicable to mitigate any such risks. Regard was not given to the Department of Health Code of Practice on the prevention and control of infections. This was in breach of regulation 12 (2)(b)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** Not all staff had received training in fire safety. Staff, including the infection control lead, were not trained in the prevention and control of infection. The cleaning schedules did not contain information to enable to staff to know exactly what cleaning duties to perform, and cleaning of the surgery was only routinely carried out once a week. Regulation 12 (b)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the registered person did not ensure systems and processes were established and operated effectively to prevent abuse of service users. This was in breach of regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** Not all staff had been trained in safeguarding children and vulnerable adults. Processes were not in place to ensure training was updated at appropriate intervals. Regulation 13(2)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	We found that the registered person did not have systems and processes such as regular audits of the service in place to assess, monitor and improve the quality and safety of the service. This was in breach of regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** There was no system in place to check the expiry date of medicines and equipment. Clinical audit cycles had not been completed. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person did not operate robust recruitment procedures to ensure they only employed fit and proper staff. This was in breach of regulation 19(1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met:** The recruitment policy did not clearly set out the process to be followed when recruiting new staff. Relevant information was not kept for all staff and not all pre-employment checks had been carried out. Regulation 19 (1)(a)(b)(2)