Dr Simria Tanvir

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

The North Hyde Practice (Dr Simria Tanvir) provides NHS services to 3150 patients within the Hillingdon Clinical Commissioning Group (CCG), who provide a service to the London borough of Hillingdon. Census data shows that there is an increasing population and the area has a higher than average proportion of black and minority ethnic groups. Life expectancy is 6.6 years lower than the national average for men and 4.7 years lower for women in the most deprived areas of Hillingdon. The proportion of people below 40 years of age is above the England average and it is below average for those over 40 years.

The North Hyde Practice operates from its own premises which include three consulting rooms, a conference room, administration rooms and patient waiting area. The practice is an individual GP practice which employs locum doctors to provide a full service to patients.

We carried out an inspection of the practice on 27 August 2014. As part of the inspection we spoke with the GP, the practice nurse, facilities manager, administration staff and patients awaiting their appointment. We also received feedback through Care Quality Commission (CQC) comment cards which were available for patients to complete prior to the visit.

The practice had systems to monitor safety and staff reported and learned from incidents. However, improvements were needed in the consistency of recording events and the frequency of submitting data to the Quality and Outcomes Framework (QOF).

We found that some clinical audits had been completed but there was no evidence of a completed audit cycle. Safeguarding procedures were in place and staff had received the appropriate training. We found an open and transparent culture amongst staff. There were arrangements in place to deal with medical emergencies and the practice had an up to date business continuity plan.

The practice had a Patient Participation Group (PPG) which met four times a year and was involved in the implementation of an annual patient survey. Patients had mixed views about accessing appointments with some saying it was difficult to contact the practice during the extended closing hours over lunch time.

We found improvements were needed to the way that the practice responded to those patients who did not speak English. The practice provided a translation service through staff translating and the use of a telephone translation service but written literature was only available in English.

The practice did not fully support patients at a time of bereavement; there was no literature or signposting to other services that may be of help to people.

The practice was able to meet the needs of the different population groups who accessed the service. It offered a range of services and worked well with other health professionals to provide appropriate referrals.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems in place to ensure patients received safe care. This included systems of reporting and learning from incidents and protecting patients from the risk of abuse. The practice had up to date child protection and safeguarding vulnerable adult's policies and staff were trained to the appropriate level. Safety was monitored and the practice responded to risk through up to date risk assessments and a patient text alert system. The practice was equipped to deal with medical emergencies.

Medicines were managed and stored correctly and an online repeat prescription service was offered. Procedures for the prevention and control of infection were in place which included a policy and risk assessment. The practice was clean and well maintained. All staff had received infection prevention and control (IPC) training. All equipment testing was up to date.

The practice staff were qualified for the role they undertook with all pre-employment checks carried out by the practice prior to employment.

Are services effective?

The practice provided a service that was effective. The practice reviewed current national guidelines provided by the National Institute for Health and Care Excellence (NICE) and submitted data to the Quality and Outcomes Framework (QOF). This information was used to improve the service provided by the practice.

The practice was working towards implementing the NHS integrated pathways and had undertaken some clinical audits. However no completed clinical audit cycle was present.

Staff received an induction programme which included mandatory training and they had yearly appraisals.

The practice worked closely with other health services. The practice attended multi-disciplinary meetings to discuss patient cases and form a strategy for joint care to be delivered.

Healthy living was promoted through literature and health checks for diabetes, blood pressure and the monitoring of chronic obstructive pulmonary diseases (COPD). However literature was only available in English.

Summary of findings

Are services caring?

Patients received a service that was caring. Patients told us that staff were responsive to their needs and the service from staff was friendly. Patient confidentiality was maintained. Patients were involved in decision making and meetings were held with carers to ensure they were fully informed of the treatment decisions taken.

Provision was made for patients who lacked the capacity to consent and the practice had policies for obtaining consent and maintaining confidentiality for patients who were under the age of sixteen.

The practice did not offer full support in time of bereavement and patients were not signposted to other organisations that could help at that time.

Are services responsive to people's needs?

Patients received services that were responsive to their needs. The practice understood the needs of their patient population and provided a service to meet spiritual, ethnic and cultural needs. Staff spoke some of the languages of the cultural groups represented and a telephone translation service was available for any languages not covered by the staff. Practice information was only available in English.

Patients could book appointments in person, by telephone or via the internet. Appointments were available on the day or could be pre booked. The practice offered telephone consultations and home visits.

The practice operated an extended lunch period and remained open for extended hours in the evening. The extended hours were welcomed by patients but concern was shown as patients found it difficult to contact the practice during the lunch period. The practice closed on a Wednesday afternoon and patients were directed by the practice answer machine to the 111 number or to the local walk in centre.

The practice used comments and other feedback from patients to improve the service.

Are services well-led?

Patients received a service that was well led. We found the practice had a clear leadership structure and an open staff culture. Governance arrangements were in place with a named lead for safeguarding, infection control, medicines management and clinical governance.

Summary of findings

Systems were in place to monitor and improve quality. The practice met with other local practices to discuss a joint response to issues that affected them. The practice also compared data from the Clinical Commissioning Group (CCG) and the Quality and Outcomes Framework (QOF).

The practice had an active Patient Participation Group (PPG) and patients left comments and suggestions in a box placed in the waiting area. Information provided from this was reviewed at monthly practice meetings.

The practice had a business continuity plan and health and safety risk assessments had been carried out.

Summary of findings

The six population groups and what we found

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

Older people
The practice provided a service to older people that was responsive to their needs. All patients over 75 years old received a named GP and care plan. Annual health checks were provided to patients. Telephone consultations and home visits were available.

The practice worked closely with other health care providers to improve the overall delivery of care.

People with long-term conditions
Patients received a service that was responsive to their needs. Routine health checks were carried out.

The practice worked closely with other care providers through the integrated care pathways (ICP) programme and working with the local rapid response team (RRT) to allow patients to manage their condition at home and avoid hospital admission.

Mothers, babies, children and young people
Mothers, babies, children and young people received a service that was responsive and had arrangements in place to meet patient needs.

Antenatal and postnatal care was provided. Immunisations and child health checks were undertaken and the practice offered sexual health advice and screening to young people.

The practice held a register of children in the care of social services and worked closely with health visitors to support these patients.

The working-age population and those recently retired
Working age people (and those recently retired) received a service that was responsive to their need. Patients were able to make appointments over the telephone or using the internet. Telephone consultations and evening appointments were available.

People in vulnerable circumstances who may have poor access to primary care
Patients in vulnerable circumstances received a service that was responsive to patient needs. All people were able to register and patients with no fixed abode were able to use the practice address for medical correspondence.

Summary of findings

The practice worked with carers to involve them in patient care and were involved in multidisciplinary meetings to discuss complex care plans. The practice held a register of patients with a learning disability and offered annual health checks to those patients on the list.	
People experiencing poor mental health People experiencing poor mental health received a service that was responsive to their needs. The practice carried out a mental health assessment as part of the annual health check and referred patients to the community mental health team. The practice continued to support patients that had been referred and attended multidisciplinary meetings with the mental health team.	

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients at the surgery and collected 26 comment cards that had been completed by patients.

Patients were happy with the service provided and said they were treated with respect and cared for. Patients told us that the care given by the GP was excellent but some patients told us that the level of care provided by locum doctors was not as good. They told us that is was easy to make an appointment for the time that they wanted to see the GP but some raised the concern that it was difficult to get through to the surgery at a lunch time to make an appointment.

Patients we spoke with who were receiving on going treatment were happy with the way their care was being managed and they were kept informed at all times.

We viewed the national GP patient survey for 2013 and found that 92% of patients who completed the survey had confidence and trust in the last GP they saw or spoke to and 85% said that the last appointment they received was convenient.

The main concern raised by patients was regarding the lack of parking at the practice. This was an issue the practice was aware of and attempting to resolve.

Areas for improvement

Action the service MUST take to improve
<Action here>

Action the service COULD take to improve
The practice should improve bereavement services for patients.

The practice must implement a full clinical audit cycle to benchmark and improve practice performance.

The practice should carry out a risk assessment in regard to the need for a defibrillator at the practice.

Dr Simria Tanvir

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector who was accompanied by a GP specialist advisor, expert by experience and practice manage who had the same authority to inspect as the CQC lead inspector.

Background to Dr Simria Tanvir

North Hyde Surgery is a small surgery located in the London Borough of Hillingdon. It currently provides NHS services to 3150 patients. The practice serves a diverse population with the majority of patients from an Asian background. The practice does not have a large older population (9%) with 43% between the age of 30 and 59 and 48% of the practice patient population under the age of 29.

The practice is situated in its own premises where the surgeries are on the ground level with ease of access for those with physical disabilities. Administration offices are situated on the upper level. There are currently three doctors at the practice, the GP provider and two locum doctors, a practice nurse and reception staff. One of the reception staff was trained as a healthcare assistant and carried out those duties when required. The practice is currently recruiting a permanent practice manager.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that is why we included them.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including

Detailed findings

NHS England (London), Hillingdon Clinical Commissioning Group and Hillingdon Healthwatch, to share what they knew. We carried out an announced visit on 27 August 2014.

During our visit we spoke with a range of staff including the GP, practice nurse and administration staff.

We spoke with patients who used the service. We observed how people were being cared for and reviewed practice policies and the audits that the practice have in place.

Are services safe?

Summary of findings

The practice had systems in place to ensure patients received safe care. This included systems of reporting and learning from incidents and protecting patients from the risk of abuse. The practice had up to date child protection and safeguarding vulnerable adult's policies and staff were trained to the appropriate level. Safety was monitored and the practice responded to risk through up to date risk assessments and a patient text alert system. The practice was equipped to deal with medical emergencies.

Medicines were managed and stored correctly and an online repeat prescription service was offered. Procedures for the prevention and control of infection were in place which included a policy and risk assessment. The practice was clean and well maintained. All staff had received infection prevention and control (IPC) training. All equipment testing was up to date.

The practice staff were qualified for the role they undertook with all pre-employment checks carried out by the practice prior to employment.

Our findings

Safe Track Record

The practice had systems in place to report and record safety incidents, complaints and safeguarding concerns to ensure good patient care and protection. This included an up to date complaints procedure, safeguarding and child protection policies. Staff had received training and were clear about their responsibilities in reporting and investigating incidents. We spoke with staff who were able to explain how they would report an incident to the GP who was the responsible person for investigating incidents.

We reviewed the significant and critical events handling policy which consisted of an explanation of the process for recording events, timescales and responsibilities and a review of actions section which documented the steps taken to find a resolution.

Learning and improvement from safety incidents

The practice maintained a log of significant events. We saw an event that was recorded about a patient who missed a referral to a 'First Fit Clinic' due to an administration error at the practice. Changes as a result of this incident included staff checking the name of the clinic and hospital on referral letters to ensure they were correctly processed. Minutes of meetings showed this event had been discussed with staff. This significant event review took place in January 2014 and there were no recorded events since this date.

Reliable safety systems and processes including safeguarding

The practice had systems in place to ensure patients' safety. These included safeguarding vulnerable adults, child protection and whistleblowing. Staff we spoke to were aware of these policies and their responsibility to report any incidents to either the GP who was the designated safeguarding lead or to external authorities such as social services. A folder containing reporting sheets and all local contact details was placed in the back reception area where it was accessible to all staff. The practice had not reported any safeguarding incidents.

All staff had received child protection and adult safeguarding training. The GP and practice nurse had received Level 3 child protection training and administration staff had received Level 2 child protection training.

Are services safe?

Monitoring Safety & Responding to Risk

The practice had a range of systems in place to monitor safety and respond to risk, which included health and safety risk assessments.

The practice had a business continuity plan which had recently been reviewed in April 2014. The plan included information to ensure the practice was able to continue to provide a service to patients and included 'buddying' with a local practice to provide essential services.

The practice offered a text messaging service to alert patients of potential health risks which were relevant to particular patient groups, for example if there was a particular high flu risk. Patients would register their mobile phone number with the surgery to receive the service. This service was also used to remind patients of review appointments and to inform them that test results were ready.

The practice had a current up to date fire risk assessment and there was a clear fire evacuation process. Fire alarms were tested weekly and we were provided evidence of the log of test dates.

We found that the practice had appropriate levels of reception staff which included full and part time staff members. We were informed that part time workers were requested to come in to cover staff shortages in busy periods and if other staff members were sick.

Medicines Management

The practice had procedures in place for the appropriate management of medicines. We viewed the practice policy which outlined instructions for the safe administration of vaccines and the ordering, storage and disposal of medications. The policy stated that the GP was the responsible named person for medicines management.

Medicines were stored in a locked cupboard within the reception area. A log was kept which recorded all medicines, needles and syringes held and their expiry dates. The log showed that they were last checked on 18 August 2014 and all were found to be in date. We saw evidence of the practice log of vaccines held.

Fridge temperatures were recorded twice daily both manually and via an electronic chip fitted to the fridge. The fridge stock was checked and all medicines were found to be in date.

Repeat prescriptions were handled by the reception staff and processed within 48 hours of receipt unless the patient requested an urgent prescription. Patients either brought their prescription to the practice or requested it on line. If a patient requested a change to their prescription, the GP was notified and would contact the patient to discuss the change before the prescription was issued. Prescription numbers were logged and patients were requested to sign for their prescription.

The practice offered an online prescription service where the receptionist could print off the request for the GP and the GP could then authorise the prescription to go straight to the pharmacy. There was only a small number of patients that used this system.

We found that the practice were unable to track which prescription pads were being held by the practice or had been issued to GP's, as there was no system in place to record the serial numbers of individual prescription pads being held in stock and no system to check out any that were given to GP's for use.

Cleanliness & Infection Control

The practice had policies and procedures in place for infection prevention and control (IPC). The IPC policy had recently been reviewed, in April 2014, and included information about hand washing and clinical waste management The practice nurse had lead responsibility for this area. Staff confirmed that they had received IPC training.

An infection control audit was carried out by the practice in April 2014 which had not identified any areas of concern.

The practice had a cleaning schedule which showed that the practice was cleaned every day except Wednesday. The schedule did not include the cleaning of the fabric privacy curtains but the facilities manager stated that they were laundered monthly although no evidence was provided to confirm this. The practice confirmed that this would be added to the cleaning schedule.

The practice had a contract in place for the disposal and collection of clinical waste. Clinical waste was stored in a locked cupboard in the courtyard at the back of the surgery. On the day of inspection a bag of clinical waste was stored in an unlocked yellow bin outside the cupboard. However the courtyard was locked and no access was available outside the practice.

Are services safe?

Staffing & Recruitment

The practice had a recruitment policy and process which included the submission of an application form, pre-employment checks and interview process.

We checked staff files which showed that appropriate checks had been carried out before employing staff. These included obtaining two professional references, photo identification, curriculum vitae (CV), Disclosure and Barring Service (DBS) checks and immunisation certificates. The files also contained interview notes, contracts of employment and job descriptions.

Dealing with Emergencies

Emergency medicines were kept in a locked drawer within the practice nurse's room. Keys were held in a secure location which was easily accessible to all staff members in an emergency. All medicines were recorded and found to be in date.

Oxygen was stored within a consulting room. A medical gasses label was visible on the door to the consulting room to alert people that gasses were held within the room. A spare oxygen cylinder was also present in the consulting room. The practice nurse checked these on a monthly basis and we were provided with evidence of the record log. The practice did not have a defibrillator but were currently reviewing this with the view to purchasing one. No risk assessment was present which outlined the risk of not having a defibrillator at the practice.

Each member of staff was up to date with their basic Life support (BLS) training.

Equipment

Equipment had been checked regularly. Portable appliance testing (PAT) on electrical equipment had been carried out in June 2013 and the practice had been informed that the test was valid for two years. We saw up to date calibration records for thermometers and fridges which showed that they had been tested in January 2014. All hard wiring had been checked in June 2013.

The practice had undergone a gas safety inspection and the certificate was issued in August 2014.

We found evidence that fire equipment was tested on an annual basis and was due on 27 August. The testing was organised by the facilities manager on the day of inspection.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice provided a service that was effective. The practice reviewed current national guidelines provided by the National Institute for Health and Care Excellence (NICE) and submitted data to the Quality and Outcomes Framework (QOF). This information was used to improve the service provided by the practice.

The practice was working towards implementing the NHS integrated pathways and had undertaken some clinical audits. However no completed clinical audit cycle was present.

Staff received an induction programme which included mandatory training and they had yearly appraisals.

The practice worked closely with other health services. The practice attended multi-disciplinary meetings to discuss patient cases and form a strategy for joint care to be delivered.

Healthy living was promoted through literature and health checks for diabetes, blood pressure and the monitoring of chronic obstructive pulmonary diseases (COPD). However literature was only available in English.

Our findings

Effective needs assessment, care & treatment in line with standards

The practice met monthly within a small learning group of practices to discuss the latest guidelines issued by the National Institute for Health and Care Excellence (NICE). The learning was taken back to the practice and discussed at monthly practice meetings. Recent meetings discussed child protection, needle stick injuries and the use of emergency equipment guidelines. NICE guidelines and other information regarding best practice issued by the Clinical Commissioning Group (CCG) were printed and sent to locum doctors to read before commencing at the practice. The GP attended clinical meetings at Brunel University to discuss best practice guidelines.

Monthly practice meetings were held where best practice in relation to consent, patient confidentiality and infection control was discussed Evidence of discussion within the meeting was present but no action points were present in the minutes.

Management, monitoring and improving outcomes for people

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The practice told us that recent figures had not been submitted due to the absence of a practice manager and the practice was working towards the integrated care pathways (ICP) approach to working. The ICP approach was used to manage the quality of healthcare and provides standard ways to manage patient conditions and provided a patient centred focus.

The last available QOF data showed that overall the practice was performing above both the CCG (97.8%) and national average (97.9%) achieving 98.1%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient views, amount of extra services offered by the practice). The practice used this information to ensure that they were on target to deliver a good service and to discuss, in both clinical and practice meetings, how service could be improved.

Are services effective?

(for example, treatment is effective)

Clinical practice had been reviewed through a series of clinical audits which were externally led by a local pharmacy team. Audits included repeat prescribing, the issuing of B12 tablets and nonsteroidal anti-inflammatory drugs (NSAID) prescribing. The NSAID audit resulted in a change to the way in which the drug was administered to all patients. It was found that it was more effective through review of updated guidance to inject the drug into patients. Prescriptions were changed to reflect this. The practice had not carried out a further audit once the changes had been implemented to see if the change was effective.

The practice had provided data to the Quality and Outcomes Framework (QOF) to benchmark their own service against others in the area. The practice also used data provided by the Clinical Commissioning Group (CCG) as a benchmark of their own service. This included looking at patient attendance at accident and emergency using a business intelligence risk stratification tool (BIRT2) issued by the CCG. The tool identified all patients who frequently used the emergency services. The practice took this data and produced care plans for the top 2% to minimise their attendance at accident and emergency. Each patient identified was called to the practice to discuss their concerns and for the practice to produce a care plan.

Clinical staff were involved in risk review meetings. A recent review identified that the practice Quality and Outcome Framework (QOF) score was low for patient health checks. The practice was addressing the issue by providing more appointments for these checks in order to improve the score.

The GP undertook an audit to improve antenatal care for patients with gestational diabetes. This consisted of monitoring blood glucose levels at each appointment. The results were not clear as to the effect glucose had on these patients. The GP stated that the results were shared within the practice and with the midwife team.

The practice met with other surgeries to discuss patient care. One area that the surgeries were currently assessing was the need for out of hours care once the local walk in centre was closed. The group planned a response to share this responsibility once the facility was no longer available.

The practice was involved in monthly integrated care pathways (ICP) meetings where cases concerning elderly care and patients with long term conditions were discussed with consultants in order to provide a care plan for the patient.

Effective Staffing, equipment and facilities

New staff were given an induction which included a review of all practice policies and procedures and any training specific to their job role. A copy of the induction programme was held on their staff file.

Staff received annual appraisals which discussed progress throughout the past year, set objectives and identified training needs for the following year. A personal development plan was completed during the appraisal meeting and filed in the employees' file. Staff we spoke with were happy with the appraisal system and were confident that their training needs were fulfilled. The GP was working towards revalidation in February 2015.

There was no formal monthly supervisory meetings but the GP had an 'open door' policy for staff to come and discuss concerns as they arose. Any serious concerns were documented and placed on file. We were informed that if there were any general issues that had arisen they were discussed during the monthly practice meeting.

The building was owned by the GP and contracts were in place to service medical equipment in line with the manufacturer's recommendations.

Working with other services

The practice engaged with other health services to ensure a multi-disciplinary approach to patient care and treatment.

We were informed that the practice had a good working relationship with the local community matrons to provide a service in patients homes. The practice had both a formal and informal working relationship with the community matrons. The GP could be contacted by the community matron to discuss patient concerns informally at any time but these phone calls were not recorded. We also viewed minutes of formal multi-disciplinary meetings between the practice and the community matron where one patient was referred to the adult safeguarding team. Another patient who was referred by the practice to the community matron was discharged as the patient made no contact. It was uncertain from the minutes if the practice followed this up by contacting the patient.

Are services effective?

(for example, treatment is effective)

The practice was involved in monthly integrated care pathways meetings which was an opportunity to discuss individual patient cases and provide specific care plans for the patient. This included meetings with primary care navigators (who help elderly patients to gain access to care) appointed by the Clinical Commissioning Group (CCG) and Age UK who worked with the practice to focus on the social aspect of care.

The practice were involved with the "Co-ordinate my care" (CMC) initiative for palliative care patients. This involved ensuring that patients had a personalised care plan that is recorded centrally to enable other services involved in the patients care to access. This included enabling access to the hospital and ambulance service as well as social services organisations as required.

The practice also had regular meetings with the community psychiatric liaison team to ensure that those patients with mental health concerns were appropriately cared for.

Health Promotion & Prevention

All new patients were offered an initial consultation where their lifestyle was discussed and information given to help improve the patient's lifestyle. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. The practice also offered a full adult and children's immunisation programme.

The practice offered annual health checks to patients which included diabetes checks, blood pressure monitoring, and chronic obstructive pulmonary disease (COPD) checks which included spirometry checks (which measured lung function). Patients who were due for annual health checks were highlighted on the computer system and a text message was sent for them to make an appointment. The health care assistant ran a weekly stop smoking clinic which patients could be referred to by the GP. All patients were also invited to attend an annual health check.

Health advice leaflets were available within the reception area and from the practice nurse. However the leaflets that were available were in English and there were no leaflets available in other languages.

Are services caring?

Summary of findings

Patients received a service that was caring. Patients told us that staff were responsive to their needs and the service from staff was friendly. Patient confidentiality was maintained. Patients were involved in decision making and meetings were held with carers to ensure they were fully informed of the treatment decisions taken.

Provision was made for patients who lacked the capacity to consent and the practicehad policies for obtaining consent and maintaining confidentiality for patients who were under the age of sixteen.

The practice did not offer full support in time of bereavement and patients were not signposted to other organisations that could help at that time.

Our findings

Respect, Dignity, Compassion & Empathy

We found staff at the practice were caring and responsive towards the needs of patients. Information was given to patients in a friendly manner. Patients commented that they found staff to be very helpful and accommodating.

We received 26 comment cards completed by patients who used the practice. All comments were positive about the staff and the care received. However some patients that we spoke with on the day commented that they received a more caring service from the permanent GP as opposed to the locum GPs who worked at the practice. 45% of participants in the national GP patient survey (2013) said that the GP was good at listening to their concerns and 32% said that the GP was very good.

The practice tried to ensure that patients' confidentiality was maintained but due to the small size of the waiting area this was as an issue because they were unable to speak confidentially at the reception desk. If patients wished to talk confidentially to staff, they were advised by staff that they could talk in confidence in one of the spare consultation rooms. All consultation rooms had curtains however the curtain in one consultation room did not give complete privacy and patients could be exposed if the door was opened. The door had a key in the lock but this was stuck and was inoperable at the time of inspection. Patients were given a choice of whether they wished to see a male or female GP.

We spoke with patients who felt that more time was needed with the GP and nurse. We spoke with the practice who stated that they responded to this by offering double appointments with information being provided to patients on the change.

The practice had a chaperone policy that was publicised in the waiting room. The policy stated that clinical staff would be used as chaperones and if none available, the examination would be postponed. Non-clinical staff would be used if the patient consented to this. Patients that we spoke to were aware of the chaperone policy and staff had received training. Staff who undertook chaperoning duties had received a Disclosure and Barring Service (DBS) check.

We were told that the practice phoned patients at the time of a bereavement to offer support and they could make an appointment with the doctor. At the appointment the GP

would discuss whether it was be appropriate if the patient needed on-going support in the form of counselling or medicines. The practice did not routinely send bereavement leaflets or signpost patients to other services who could provide help. There were no bereavement poster or leaflets available in the reception area.

Involvement in decisions and consent

We found that patients were involved in decisions about their treatment. In the GP Patient survey 41% of participants said that they felt involved in the decisions about their care. Patients said that they were listened to and that the GP explained the medical position and then a joint treatment decision, within the best interest of the patient was taken. Regular meetings with patients and their carers took place to ensure that carers were fully informed of decisions taken about treatment. Verbal information was given to patients in a number of languages. Staff members spoke many languages which included Punjabi, Hindi and Urdu. A language line translation service was used for any other language translation requested by the patient. Written communication was only available in English.

The practice had a Mental Capacity Act 2005 (MCA) policy which outlined the core principles of the MCA and how the practice would implement those principles. The policy included how to assess patients' capacity to consent and how to act in patients' best interests. Staff had received training in both the MCA and the practice policy and were aware of their responsibilities under it.

The practice used Gillick competencies to assess the capacity of patients under the age of sixteen to consent. We saw evidence of the assessment tool used by the practice to gauge whether it was appropriate for the patient to give consent. The GP would assess each patient on an individual basis and if it was viewed that the patient did not have the capacity it could be hard to treat without involving parents?. In these cases, the GP would refer to secondary care such as a family planning service for the patient to receive further care and advice.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Patients received services that were responsive to their needs. The practice understood the needs of their patient population and provided a service to meet spiritual, ethnic and cultural needs. Staff spoke some of the languages of the cultural groups represented and a telephone translation service was available for any languages not covered by the staff. Practice information was only available in English.

Patients could book appointments in person, by telephone or via the internet. Appointments were available on the day or could be pre booked. The practice offered telephone consultations and home visits.

The practice operated an extended lunch period and remained open for extended hours in the evening. The extended hours were welcomed by patients but concern was shown as patients found it difficult to contact the practice during the lunch period. The practice closed on a Wednesday afternoon and patients were directed by the practice answer machine to the 111 number or to the local walk in centre.

The practice used comments and other feedback from patients to improve the service.

Our findings

Responding to people's needs

The practice understood the need of the patient population it served and provided some services to meet those needs. This included regular clinics for diabetes, asthma, chronic obstructive pulmonary disease (COPD), ante natal and post natal classes. The practice had access to a counsellor for one day per week and had links with a local mental health facility where patients could be referred.

No written information was available in the main community languages and this included the patient leaflet which provided information about the practice. Staff members translated for some patients and a language line translation service was available. A poster was on display in the reception area publicising the translation service. Patients were able to request to see a GP of the same gender. The practice was situated on the ground floor with good access for wheelchairs.

For patients who required a referral to another health professional, the practice offered a two week referral.

Out of hours provision was advertised within the practice. The contact information was also available on the practice answer machine along with the NHS 111 number.

The practice ran a Patient Participation Group (PPG) which met together three times a year to present patient matters to the practice management and was responsible for the annual patient survey.

Access to the service

The practice operated an appointment booking system where patients could either book an appointment by calling into the practice or by telephone. Appointments could also be booked online through a secure website. Same day appointments were available or appointments could be booked in advance. Patients had mixed views regarding access to appointments. Most found the system helpful and easy to make an appointment but some found it difficult to get a same day appointment if they called the practice in the morning.

Staff informed us that if a cancellation was received, the receptionist contacted the first person on the list of patients who were unable to get a same day appointment to offer them the slot. The national GP patient survey

Are services responsive to people's needs?

(for example, to feedback?)

showed that 42% found it fairly easy to access the practice via the telephone and 35% found it very easy. The survey also showed that 33% said that the experience of making an appointment is very good and 33% said it was fairly good.

The practice closed each day between 12 and 4pm and was open between 4pm and 6.30pm. The practice closed on a Wednesday afternoon. Patients raised concerns over the opening times stating that the long closing time for lunch was a problem as it was difficult to get through to the practice on the telephone. Staff confirmed the practice answer machine was operational during Wednesday afternoon and directed patients to the local walk in centre, the 111 number or accident and emergency at the local hospital.

The practice offered telephone consultations at the end of each surgery session which were received well by patients who had difficulty attending the surgery due to work commitments. Home visits were made by the GP during the extended lunch closure.

Meeting people's needs

The practice took into account patients spiritual, ethnic and cultural needs when treatment was planned and delivered. This included giving patients a choice of seeing a male or female doctor, and we were informed by the GP that the practice respected the beliefs of patients, for example Jehovah's Witnesses wishes were respected regarding the refusal to have blood tests. However we found no policy for this. The practice ensured that all treatment options were fully explained by the GP and the choice of treatment was made by the patient. For example, for parents who refused to give their children the combined MMR vaccination, the GP outlined the risks involved but left the choice to the parent.

If patients required a referral for further treatment they received a copy of their referral letter and the GP explained what would happen at the referral appointment. Patients stated that they were contacted promptly by the practice regarding their test results and found the text messaging reminder service helpful.

Concerns & Complaints

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

The complaints procedure was displayed within the waiting area and a separate complaints leaflet was available on request outlining the procedure and how to make a complaint.

We viewed the complaints file and found that complaints had been responded to in line with the policy and responses had been sent by the practice within the three working days given. We reviewed one complaint and the issue had been suitably resolved.

Are services well-led?

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

Summary of findings

Patients received a service that was well led. We found the practice had a clear leadership structure and an open staff culture. Governance arrangements were in place with a named lead for safeguarding, infection control, medicines management and clinical governance.

Systems were in place to monitor and improve quality. The practice met with other local practices to discuss a joint response to issues that affected them. The practice also compared data from the Clinical Commissioning Group (CCG) and the Quality and Outcomes Framework (QOF).

The practice had an active Patient Participation Group (PPG) and patients left comments and suggestions in a box placed in the waiting area. Information provided from this was reviewed at monthly practice meetings.

The practice had a business continuity plan and health and safety risk assessments had been carried out.

Our findings

Leadership & Culture

The practice was led by the GP and staff said there was clear leadership and an open culture which was evident through observing staff interactions. The GP adopted an 'open door' policy for staff to share concerns. Staff stated that there was a culture of good team working and open communication. Staff were happy to work there and they felt valued as employees.

The practice had a written statement of purpose which outlined its aims and objectives. The statement was reviewed in March 2014 and shared with all staff at the practice meeting. The staff we asked stated that they worked hard to realise the aims and objectives of the practice. The practice had a clear vision to expand to offer phlebotomy and minor surgery which had also been shared with staff.

Governance Arrangements

The practice had named leads for clinical governance, medicines management, safeguarding and infection control. The practice had a monthly governance meeting where most of the clinical staff were asked to attend. Concerns were discussed in the meeting and fed back to staff in the practice meeting. The locum doctors did not attend these meetings and we were informed that they were invited but the meetings were not on days they worked. However they were sent copies of the minutes. Staff we spoke with felt their views were taken on board by the leadership team and that they were able to make a difference within the practice.

Systems to monitor and improve quality & improvement (leadership)

We found that the practice participated in meetings involving a small group of practices within the local area. The group met monthly to discuss common issues faced by the practices that may affect patients. Currently the group were discussing a response to the proposed closure of a local walk in centre and how the surgeries could share the responsibility for providing an extra service to meet patient need.

The practice had provided data to the Quality and Outcomes Framework (QOF) to benchmark their own

Are services well-led?

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

service against others in the area. The practice also used data provided by the Clinical Commissioning Group (CCG) as a benchmark of their own service and included the business intelligence risk stratification tool (BIRT2).

Patient Experience & Involvement

Patients were invited to leave comments and suggestions in a box placed within the waiting area. We reviewed comments that were positive about the service but the issue of parking at the practice was raised. The practice was aware of the issue and was in the process of trying to acquire the use of a local public house car park for the use of patients during practice opening times. These comments were discussed in practice meetings and necessary action taken.

The practice had a Patient Participation Group (PPG) which was formed three years ago and consisted of ten members. The PPG met three times a year. We viewed minutes of a recent PPG meeting which was attended by PPG and staff members during which the patient survey and the issue of parking at the practice was discussed.

We viewed the national GP patient survey for 2013 and found that 92% of patients who completed the survey had confidence and trust in the last GP they saw or spoke to and 85% said that the last appointment they received was convenient.

The practice also reviewed comments left on the NHS Choices website which were mainly positive.

Practice seeks and acts on feedback from users, public and staff

The PPG were involved in the production of the annual patient survey. We found that 122 patients completed the latest survey dated February 2014. The survey asked patients to rate aspects of the practice such as waiting times, time given for the appointment, telephone access and the respect for privacy and confidentiality. The survey produced a positive result and staff compared their scores with the national average scores for practices of a similar size and found that they were performing well for areas such as respect for privacy and confidentiality but below the national average for areas such as comfort in the waiting room and length of time for consultations. The practice took the main areas of concern identified within the survey and produced an action plan to improve service. For example patients felt that more time was needed with the GP and nurse and the practice responded by offering double appointments with information being provided to patients on the change.

Staff felt valued as employees and felt at ease to provide feedback to the GP knowing that it would be acted upon. We viewed the whistleblowing policy and staff were aware of how to use the policy and who to report concerns to.

Management lead through learning & improvement

The practice had a culture of continual staff training. We saw evidence within staff files where individuals had action plans with objectives set at their appraisals which included further training. Staff confirmed that training that training requested in the previous year's appraisal had taken place. The staff training matrix outlined what training had been undertaken by staff and confirmed that all mandatory training had taken place. Dates of training were documented within staff files and it was found that all training was in date.

Identification & Management of Risk

The practice had systems in place for identifying and managing risk to patients. This included the use of health and safety risk assessments and a business continuity plan.

Clinical staff were involved in risk review meetings. A recent review identified that the practice Quality and Outcome Framework (QOF) score was low for patient health checks. The practice was addressing the issue by providing more appointments for these checks in order to improve the score.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice provided a service to older people that was responsive to their needs. All patients over 75 years old received a named GP and care plan. Annual health checks were provided to patients. Telephone consultations and home visits were available.

The practice worked closely with other health care providers to improve the overall delivery of care.

Our findings

The practice had signed up to the Clinical Commissioning Group (CCG) initiated integrated care pathways (ICP) which ensured that all patients over the age of 75 had a named GP and that care plans were provided for older people. Patients who were unable to attend the practice were offered a telephone consultation or home visit.

Older people received a yearly routine health check which included monitoring their blood pressure and a seasonal flu jab. Patients were referred when necessary by the GP to the tissue viability nurse who worked closely with the practice.

The practice attended twice yearly multi-disciplinary meetings with other community services such as social services, community matron and district nurses to discuss the care of older people on the patient list. Staff said that this meeting was helpful for building relationships within the community which in turn helped improve the overall delivery of care. This included developing effective ways to treat patients within their own home to avoid admittance to hospital.

The practice had close links with the community matron and district nurse service who met regularly to discuss individual patients on the community matron list.

The practice did not offer services to any local care homes.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Patients received a service that was responsive to their needs. Routine health checks were carried out.

The practice worked closely with other care providers through the integrated care pathways (ICP) programme and working with the local rapid response team (RRT) to allow patients to manage their condition at home and avoid hospital admission.

Our findings

Support was given to patients with long term conditions and their carers by the practice. Routine health checks were carried out by the GP and practice nurse for those on the practice chronic diseases register. Patients appreciated the text messaging service provided to alert them and remind them to make an appointment for the check. The practice also provided clinics for the monitoring of asthma, diabetes and chronic obstructive pulmonary disease (COPD).

As part of the practice's commitment to the integrated care pathways programme (ICP), each patient on the chronic diseases register had a named GP and a care plan which they were able to take to aid them and their carer to plan care at home.

The practice undertook joint work with the local rapid response team (RTT) to help patients stay in their own home to receive treatment for their condition rather than being admitted to hospital. The practice were also involved with the "Co-ordinate my care" (CMC) initiative for palliative care patients. This was an initiative where clinical services shared information with health care providers and gave patients the opportunity to express how they would like to be cared for.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Mothers, babies, children and young people received a service that was responsive and had arrangements in place to meet patient needs.

Antenatal and postnatal care was provided. Immunisations and child health checks were undertaken and the practice offered sexual health advice and screening to young people.

The practice held a register of children in the care of social services and worked closely with health visitors to support these patients.

Our findings

The practice undertook a child immunisation programme with a 100% immunisation rate and regular child development checks. The practice worked closely with community health visitors and midwives. The practice also provided antenatal and postnatal care. Cervical screening was also provided by the practice.

The practice had a policy for looked after children which included those children who had been placed in the care of social services. This policy included the identification of looked after children and an initial health assessment being carried out. The practice held a register of those children who were in the care of social services and worked closely with health visitors in the support of their care.

The practice offered sexual advice to patients which included providing patients with health advice literature. All young people who registered as new patients were offered chlamydia screening as routine. Existing patients were periodically invited to attend a chlamydia screening. The practice also offered screening for other sexually transmitted diseases.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Working age people (and those recently retired) received a service that was responsive to their need. Patients were able to make appointments over the telephone or using the internet. Telephone consultations and evening appointments were available.

Our findings

The practice offered a flexible appointment system which included extended opening hours in the evening allowing patients who worked to attend the surgery. Patients provided positive feedback about the practice opening to 6.30pm and that they were able to make an appointment for their chosen time using the internet to avoid waiting on the telephone. Telephone consultations were also available for patients who were unable to come to the surgery.

Patients were offered a flexible referral system which enabled them to be seen at healthcare facilities closer to where they worked if it was more convenient to do so.

The health care assistant ran a weekly smoking cessation clinic which patients could be referred to by the GP. All patients were also invited to attend an annual health check.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Patients in vulnerable circumstances received a service that was responsive to patient needs. All people were able to register and patients with no fixed abode were able to use the practice address for medical correspondence.

The practice worked with carers to involve them in patient care and were involved in multidisciplinary meetings to discuss complex care plans.

The practice held a register of patients with a learning disability and offered annual health checks to those patients on the list.

Our findings

The practice had a policy to register and treat those patients with no fixed abode. The practice address was used for any patient correspondence such as test results and referral letters on the advice of the clinical commissioning group (CCG). The practice also provided care for asylum seekers who were housed in a nearby hostel.

The practice had a protocol for the identification of patients with learning disabilities which defined what a learning disability was and how to identify one. The practice had six patients on the learning disability register and each had received their annual health check which included a physical examination, and checks on behaviour, mental health, specific syndrome, medication and any secondary care coordination. Double appointments were offered to those patients with learning disabilities to allow time for all health concerns to be discussed. The practice worked closely with carers to involve them in patient care. This included inviting carers to patient appointments. The practice was also involved in multi-disciplinary meetings with other care providers to discuss care plans for complex cases.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

People experiencing poor mental health received a service that was responsive to their needs. The practice carried out a mental health assessment as part of the annual health check and referred patients to the community mental health team. The practice continued to support patients that had been referred and attended multidisciplinary meetings with the mental health team.

Our findings

The practice had procedures in place to meet the needs of people experiencing poor mental health which included a named GP to allow consistency of care. Patients were assessed by the practice using a depression questionnaire and annual health review. Where patients were assessed to have a mental health problem they were referred to the community mental health team or counselling service. The practice also referred patients to a mental health facility.

The practice worked closely with the mental health team and attended multi-disciplinary meetings to discuss the care of patients and how the GP could continue to support patients.

Staff at the practice had been trained in the Mental Capacity Act 2005 and showed good awareness of their obligations under it.

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.

This section is primarily information for the provider

Enforcement 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.