# Dr Naz Asghar

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Dr Naz Asghar also known as the Welcome Practice on 2 August 2016. Overall, the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing a safe and effective service and being well led. It was also inadequate for providing services for; older people, people with long-term conditions, families, children and young people, working age people, people whose circumstances make them vulnerable and people experiencing poor mental health. It was requires improvement for providing a caring service and good for providing a responsive service. Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, staff were not clear about reporting incidents, near misses and concerns. Reviews and investigations were not thorough. Appropriate recruitment checks on staff had not been undertaken prior to their employment.
- Not all risks to patients were assessments well managed.
- There was no induction programme for non-clinical staff and there was no evidence they had been given information on reporting significant events, fire safety and health and safety.
- Data showed patient outcomes were low compared to the local and national average. Although some audits had been carried out, we saw no evidence that audits were driving improvements to patient outcomes.
- Patients said they were involved in their care and decisions about their treatment.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- The practice had no clear leadership structure, insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

# Summary of findings

- Introduce clear and effective processes for reporting, recording, acting on and learning from significant events, incidents and near misses.
- Ensure that appropriate risk assessments are in place for; fire safety, health and safety and electrical equipment.
- Ensure there is a defibrillator available at the practice or a risk assessment to indicate the risks of not having one have been assessed.
- Provide staff with appropriate training and appraisals to carry out their roles in a safe and effective manner that are reflective of the requirements of the practice.
- Ensure that DBS checks are undertaken as part of the recruitment process for all staff employed at the practice or a risk assessment to indicate the risks of not having one have been assessed.

The areas where the provider should make improvement are:

- Update arrangements in place to ensure that patients with caring responsibilities are identified, so their needs are identified and can be met.
- Provide patients with long-term conditions with person centred care, such as, improving the care provided to patients with asthma and review the care and treatment provided to patients with mental health problems, dementia and diabetes.
- Update policies and processes to improve screening uptake for cervical cytology.
- Improve arrangements so that all equipment used at the practice is calibrated and tested at regular intervals.
- Update the process for recording discussions during all internal meetings.
- Revise the leadership structure and ensure there is leadership capacity to deliver all the required improvements.
- Implement a programme of quality improvement such as clinical audits to improve outcomes for patients.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Special measures will give people who use the service the reassurance that the care they get should improve.

**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?**

**Inadequate**

The practice is rated as inadequate for providing safe services.

- Not all staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things were reported to the GP patents received support and a written apology.Reviews and investigations, however, were not undertaken and lessons learned were not communicated to support improvement.
- Patients were at risk of harm because systems and processes were not in place.For example, appropriate risk assessments were not implemented, including; fire safety, health and safety and electrical equipment.
- Some arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.However, there was limited management capacity to deal with day-to-day issues, as the position of practice manager was vacant and the provider had no plans to recruit a replacement.
- There was no formal induction programme for non-clinical staff and there was no evidence they had been given information on how to report and deal with significant events, fire safety and health and safety.

**Are services effective?**

**Inadequate**

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made.

- Data showed patient outcomes were below the local and national average for mental health, diabetes, cervical smears, asthma and hypertension indicators.
- The practice had undertaken two completed audits in the past two years; however, there was little evidence that these audits were driving improvement to patient outcomes.
- There was no recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.
- Staff worked with other health care professionals to understand and meet the range and complexity of patient needs.

**Are services caring?**

**Requires improvement**

The practice is requires improvement for providing caring services.

# Summary of findings

- Data from the national GP patient survey showed patients rated the practice as below the local and national average for several aspects of care.
- Patients interviewed during the inspection said they were treated with compassion, dignity and respect and they felt cared for, supported and listened to.
- Information for patients about the services was available, easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained patient information and confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

- Data from the national GP patient survey showed patients rated the practice as comparable to the local and national average for several aspects of care.
- Patients could get information about how to complain in a format they could understand.
- Practice staff 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. For example, the practice worked with the local CCG to provide an in-house counselling service once a week.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

**Are services well-led?**

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision to deliver care and promote good outcomes for patients; however, they did nothave the required systems and processes in place to support that vision.
- The practice had a system in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).The practice did not, however, have systems in place to ensure that staff were always aware of their responsibility to report such incidents and the practice did not always review incidents thoroughly and there was no system to share learning with staff not in attendance at meetings.

# Summary of findings

- There was a leadership structure and staff told us they felt supported by management. However, there was no practice manager to support the GP with the day-to-day management of the practice.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings, however, there was no record of discussions taking place during these meetings so staff not in attendance were not kept up to date with discussions and actions.
- Staff told us that the practice had sought feedback from them during ad hoc meetings; however, there was no evidence that the feedback was recorded or acted upon.
- There was no recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.
- The practice had a patient participation group and sought feedback from them to make improvements for patients.
- Staff told us they had not received regular performance reviews and did not have clear objectives.

# 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

Inadequate

The provider was rated as inadequate for safety, Effective and Well-led, and requires improvement for caring and good for responsive. The issues are identified are inadequate overall affected all patients including this population group:

- The practice provided care to meet the needs of the older people in its population.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- Patients had a named GP and an annual review to check.
- For patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice provided 122 from 211 patients over 74 with health checks.
- The practice provided elderly housebound patients with health checks.

### People with long term conditions

Inadequate

The provider was rated as inadequate for safety, Effective and Well-led, and requires improvement for caring and good for responsive. The issues are identified are inadequate overall affected all patients including this population group:

- Performance for diabetes related indicators was below the local and national average, for instance:
- 64%, of patients with diabetes on the register had their blood sugar recorded as well controlled (local average 71%, national average 78%). The exception-reporting rate was 33%.
- 69%, of patients with diabetes on the register had their cholesterol measured as well controlled (local average 75%, national average 81%). The exception reporting rate was 17%.
- 90% of patients with diabetes on the register had a recorded foot examination and risk classification (local average 88%, national average 88%). The exception reporting rate was 5%.
- Longer appointments and home visits were available when needed, except for Wednesday afternoons when the practice is closed.
- Patients had a named GP and an annual review to check.

# Summary of findings

- For patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Inadequate

The provider was rated as inadequate for safety, Effective and Well-led, and requires improvement for caring and good for responsive. The issues are identified are inadequate overall affected all patients including this population group:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances, however, childhood immunisation rates were below the local average.
- 82% of patients diagnosed with asthma had an asthma review in the last 12 months; this was comparable to the local average of 79% and national average of 75%. The exception reporting rate was 3%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- 64% of women aged 25-64 had it recorded on their notes that a cervical screening test has been performed in the preceding five years; this was below the local average of 78% and national average of 82%. The exception reporting rate was 5%.
- Appointments were available outside of school hours, except on Wednesday afternoons, when patients can call the local 111 service.
- We saw examples of joint working with midwives and health visitors.

**Working age people (including those recently retired and students)**

Inadequate

The provider was rated as inadequate for safety, Effective and Well-led, and requires improvement for caring and good for responsive. The issues are identified are inadequate overall affected all patients including this population group:

- The needs of the working age population, those recently retired and students had been identified.
- The practice offered online services and a range of health promotion and screening.
- The practice offered extended opening hours on Tuesday evenings.

# Summary of findings

**People whose circumstances may make them vulnerable**

Inadequate

The provider was rated as inadequate for safety, Effective and Well-led, and requires improvement for caring and good for responsive. The issues are identified are inadequate overall affected all patients including this population group:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups.
- The practice had 10 patients with a learning disability and 80% of them had received an annual health check.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. However, not all staff had received training for them to be aware of their responsibilities in respect of information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Inadequate

The provider was rated as inadequate for safety, Effective and Well-led, and requires improvement for caring and good for responsive. The issues are identified are inadequate overall affected all patients including this population group:

- Performance for mental health related indicators was below the local and national average:
- 100% of patients diagnosed with dementia had a recorded review in a face-to-face meeting in the last 12 months (local average 87%, national average 84%).The exception reporting rate was 37%.
- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (local average 92%, national average 90%).The exception reporting rate was 25%.

# Summary of findings

- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the last 12 months (local average 90%, national average 88%).The exception reporting rate was 18%.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out care planning for patients with dementia.
- The practice provided health checks for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had an understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Four hundred and three survey forms were distributed and 125 were returned. This represented 4% of the practice's patient list.

Results from the national GP patient survey showed patients responded positively to questions relating to appointments and access. Some of the results were in line with local and national averages. For example:

- 62% found it easy to get through to the surgery by phone, (local average 69%, national 73%).
- 67% were able to get an appointment to see or speak to someone the last time they tried, (local average 69%, national average 76%).
- 71% described the overall experience of their GP surgery as fairly good or very good, (local average 78%, national average 85%).

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 28 comment cards that were all positive about the standard of care received.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

# Dr Naz Asghar

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

## Background to Dr Naz Asghar

Dr Naz Asghar, also known as the Welcome Practice, provides primary medical services in the London Borough of Ealing to approximately 3,000 patients. The practice operates under a General Medical Services (GMS) contract and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract).

The practice operates from one site. The surgery is a converted residential property over two floors. There is stepped and ramp access to the ground floor waiting area and reception desk. The ground floor also comprises four consulting rooms and one nursing room. The first floor comprises practice management facilities including staff room, meeting room and offices.

The practice clinical team is made up of one fulltime female GP partner, one fulltime female GP locum, one part time male GP locum, one part time practice nurse, one fulltime healthcare assistant (HCA) and other non-clinical staff.

The practice opens between 8.15am and 6.30pm Monday, Tuesday, Thursday and Friday. The practice opens between 8:15am and 1:15pm on Wednesday.

Telephone lines are operational between the hours of 8.00am and 6:30pm on a Monday, Tuesday, Thursday and Friday. Telephone lines are operational between the hours of 8.00am and 1:30pm on Wednesday, after which they are diverted to the local 111 emergency line.

Appointments are available between 8:30am and 6:30pm on Monday, Tuesday, Thursday and Friday. Appointments are available between 8:30am and 1:30pm on Wednesdays.

Extended hours are available on Tuesday from 6.30pm until 8.00pm.

When the practice is closed, patients can call NHS 111 to access the out of hours service.

The practice is registered with the Care Quality Commission to provide the regulated activities of; treatment of disease, disorder or injury, diagnostic and screening procedures.

## 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. The 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.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 August 2016. During our visit we:

- Spoke with a range of staff two GPs, one practice nurse, one HCA, four non-clinical staff members.
- Spoke with five patients.
- Spoke with one member of the Patient Participation Group.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed 28 comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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.

Inadequate

# Are services safe?

## Our findings

**Safe track record and learning**

The system for reporting and recording significant events was not effective because not all staff were aware of the policy.

- Only some members of staff were aware of their responsibility to inform the GP of any incidents.There was a recording form available on the practice's computer system that supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when the GP was made aware of things going wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information and a written apology.
- The practice did not undertake thorough analysis of the significant events.For example,incidents were discussed at ad hoc meetings and no records were maintained of discussions that took place and there was no system to ensure staff not in attendance were updated with relevant information.

We reviewed safety records, incident reports and patient safety alerts. For example, a courier service delivering new patient medical records left them on the front step of the practice at 6:00am in the morning, without ensuring that staff at the practice were aware of the delivery. The error was reported to the service provider and the matter was escalated to NHS England. The event was addressed in line with the practice policy and was discussed at the next team meeting. The practice informed us that following the incident they developed a system in conjunction with the service provider to ensure that all future deliveries were signed for by a member of staff at the practice. Staff we spoke with confirmed that training had been provided to ensure that they were familiar with the process.

**Overview of safety systems and processes**

The practice had some defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurses were trained to child protection or child safeguarding level 3 and the HCA was trained to level 2. All non-clinical staff were trained to child protection or child safeguarding level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role, however, they had not received a Disclosure and Barring Service (DBS) check when commencing work at the practice The practice had not undertaken a risk assessment to mitigate the risk. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of

patients who may not be individually identified before presentation for treatment). The practice had a system for production of Patient Specific Directions (PSD) to enable Health Care Assistants to administer vaccines after specific training when a doctor was on the premises (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).

- We reviewed five personnel files and found that recruitment checks undertaken prior to employment of permanent, contract and locum staff to be incomplete. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service had all been undertaken for most staff, however, for some non-clinical members of staff there were no interview notes, summaries or current DBS certificates (or an appropriate risk assessment demonstrating that the practice had considered and mitigated against the risk of not undertaking a DBS check).

**Monitoring risks to patients**

Some risks to patients were assessed and appropriately managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives, however, not all staff had been provided with the relevant training. The practice had up to date fire risk assessments, however, they did not carry out regular fire drills and not all staff had the required training. Electrical equipment had not been checked within the past 12 months to ensure the equipment was safe to use and clinical equipment was not checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Some arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. However, there was limited management capacity and no one in the practice had overall responsibility for the day to day management of the practice, because the position of practice manager was vacant and the provider told us they had no plans to recruit a new one. The GP lacked capacity to both manage the practice and provide patients with effective medical care.

**Arrangements to deal with emergencies and major incidents**

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice did not have a defibrillator available on the premises and had not carried out a risk assessment to indicate they had assessed the risks to patients and staff of not having one.
- Oxygen was available at the premises with adult and children's masks.
- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice assessed the needs of some their patient needs and delivered some care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE. However, for example, high Quality and Outcomes Framework (QOF) exception reporting for most patient groups showed that they did not always use this information to deliver care and treatment that met peoples' needs.
- The practice did not always monitor that these guidelines were followed through risk assessments, audits and random sample checks of patient records.For example, clinical audits undertaken by the practice did not demonstrate that they were driving improvement.

**Management, monitoring and improving outcomes for people**

There was some evidence that the practice used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014 - 2015 showed;

- Performance for diabetes related indicators was below the national average.For example:

  • 64, of patients with diabetes on the register had their blood sugar recorded as well controlled (local average 71%, national average 78%). The exception reporting rate was 33% (82 patients).

  • 69%, of patients with diabetes on the register had their cholesterol measured as well controlled (local average 75%, national average 81%). The exception reporting rate was 17% (43 patients).

  • 90% of patients with diabetes on the register had a recorded foot examination and risk classification (local average 88%, national average 88%). The exception reporting rate was 5%.

- The percentage of patients with hypertension having regular blood pressure tests was below the local and national average:
- 80% of patients with hypertension had a blood pressure reading of 150/90mmHg or less (local average 82%, national average 84%). The exception reporting rate was 8%.
- Performance for mental health related indicators was below the national average.For example:
- 100% of patients diagnosed with dementia had a recorded review in a face-to-face meeting in the last 12 months (local average 87%, national average 84%).The exception reporting rate was 37% (6 patients).
- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months (local average 92%, national average 90%).The exception reporting rate was 25% (7 patients).
- 100% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan recorded in the last 12 months (local average 90%, national average 88%).The exception reporting rate was 18% (5 patients).

The GP during the inspection was unable to explain the reason for the high QOF exception reporting or what they intended to do to improve the number of patients receiving appropriate care and treatment.

The practice had undertaken clinical audits, however, there was only some evidence that these audits were driving quality improvement, for example:

There had been two clinical audits undertaken within the last two years, both of which were completed audits where the improvements made were implemented and

monitored. For example, an audit looking into prescribing for Atrial Fibrillation (AF), New Oral Anticoagulants (NOACS). NOACS is a long-standing treatment option for patients with AF, to prevent strokes and systemic embolism.

The first cycle of the audit found that all but two patients had been prescribed the appropriate dose of NOACS. Two patients were found to have been prescribed a slightly lower dose; the practice called those patients in for a review and amended their prescriptions accordingly. The second cycle found that all patients had been prescribed NOACS in line with NICE guidelines.

**Effective staffing**

Staff had some skills, knowledge and experience to deliver effective care and treatment.

- The practice did not have an induction programme for all newly appointed non-clinical staff. However, the practice could demonstrate how they ensured role-specific training and updating for clinical staff. For example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training that had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of non-clinical staff were not identified, as there was no system of appraisals, meetings and reviews of practice development needs. Staff did not have access to appropriate training to meet their learning needs and to cover the scope of their work, including ongoing support, one-to-one meetings, coaching and mentoring. Not all staff had received an appraisal within the last 12 months.
- Non-clinical staff did not receive training in fire safety awareness, health and safety or significant event reporting.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

**Consent to care and treatment**

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

**Supporting patients to live healthier lives**

The practice identified some patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients were signposted to the relevant service.
- A dietician was available by referral and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 64%, which was below the national average of 82%. The practice said they offered telephone reminders for

Inadequate

# Are services effective?

## (for example, treatment is effective)

patients who did not attend for their cervical screening test. There was a system in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. For example, the practice did not have an action plan for how to improve the number of women who attended for a cervical smear.

There was some evidence that the practice encouraged patients to attend national screening programmes for bowel and breast cancer screening, for example:

- 67% of female patients at the practice aged 50-70 had been screened for breast cancer in last 36 months (local average 65% and national average 72%).
- 37% of patients at the practice aged 60-69 had been screened for bowel cancer within the past 30 months (local average 43% and 55% national average).

The practice encouraged patients to take part in cancer screening programs, for example, the practice contacted by telephone 142 patients from the 147 none responders to the bowel cancer screening in 2015/2016.

The practice provided patients with smoking cessation support, for example, 93% of patients at the practice had their smoking status recorded on their notes and 83% of patients listed as smokers were provided with some form of support and 79% were referred for further support.

Childhood immunisation rates for the vaccines given were below the local average. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 28% to 87% (local 83% to 94%) and five year olds from 65% to 95% (local 69% to 94%).

Patients had access to health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 28 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey were below the local and national average for patients feeling as though they were treated with compassion, dignity and respect. For example:

- 73% said the GP was good at listening to them (local average 84%, national average 88%).
- 74% said the GP gave them enough time (local average 80%, national average 86%).

**Care planning and involvement in decisions about care and treatment**

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients rated the practice as below the local and national average to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 70% said the last GP they saw was good at explaining tests and treatments, (local average 80%, national average 86%).
- 72% said the last GP they saw was good at involving them in decisions about their care (local average 74%, national average 82%).
- 81% said the last nurse they saw was good at explaining tests and treatments (local average 83%, national average 90%).

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

**Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area, which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 28 patients as carers (less than 1% of the practice list). The practice used their register to improve care for carers, for example carers were offered flexible appointment times and the seasonal influenza vaccine. Written information was available to direct carers to the various avenues of support available to them.

Requires improvement

# Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure improvements to services where these were identified. For example, the practice provides patients an in-house counselling service once a week.

- The practice offered extended hours between 6:30pm and 8:00pm every Tuesday.
- When the practice is closed, patients can call NHS 111 to access the out of hours service.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs, which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

**Access to the service**

- The practice is open between 8:15am and 6:30pm Monday, Tuesday, Thursday and Friday. On Wednesday, the practice is open between 8:15am to 1:30pm, after which calls are diverted to the local 111 emergency line to access the local out of hours service.
- In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available on the same day for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to the local and national averages.

- 73% of patients were satisfied with the practice's opening hours (local average 73%, national average 78%).
- 62% patients said they could get through easily to the surgery by phone (local average 69%, national average 73%).
- 25% patients said they always or almost always see or speak to the GP they prefer (local average 28%, national average 36%).double check data.

People told us on the day of the inspection that they were able to get appointments when they needed them.

**Listening and learning from concerns and complaints**

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, posters were displayed in the waiting area and leaflets were available for patients at the reception desk.

We looked at three complaints received in the last 12 months and found that the practice provided patients concerned with a written apology. For example, a patient complained about that there was a delay in making a hospital referral. The complaint was dealt with in line with the practice policy; it was investigated, responded to and discussed at the next team meeting. The practice apologised to the patient and explained that the delay was due to the Christmas holiday period.

# Are services well-led?

Inadequate

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

## Our findings

**Vision and strategy**

The GP had a vision to deliver care and promote good outcomes for patients, however, they did not always have the required systems and processes in place to support that vision, for example:

- The GP had a mission statement that staff were aware of and understood. However, the GP did not have a strategy and supporting business plans that reflected the vision and values and were regularly monitored. For example, the GP did not provide all non-clinical staff with the training they required to perform their duties in line with this strategy.

**Governance arrangements**

The GP did not have appropriate governance arrangements in place which supported the delivery of the strategy and good quality care, for example:

- Most practice specific policies were implemented and were available to all staff; however, there was a lack of training for non-clinical staff.For example, non-clinical staff were not trained to deal with significant events, incidents and near misses, fire safety and health and safety.
- There were no systems in place to identify further training needs for non-clinical staff, as they did not have appraisals at regular intervals.
- There was no staff recruitment policy and the practice had not considered whether DBS checks were required.
- There was limited evidence that a comprehensive understanding of the performance of the practice was maintained.For example, there had been two clinical audits undertaken within the last two years, both of which were completed audits as recommended or required by the local clinical commissioning group. There was no evidence that audits were used to monitor quality and to make improvements.However, there was some evidence that improvements had been made and monitored following these audits.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not suitable. For example, patients were at risk of harm because systems and processes were not in place, including but not some to; fire safety, health and safety and electrical equipment.
- Some arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.However, there was some management capacity to deal with day-to-day issues, as the position of practice management was vacant and a suitable replacement had not been appointed.There was, however, a staffing structure and staff were aware of their own roles and responsibilities.

**Leadership and culture**

On the day of inspection, staff told us the GP was approachable and always took the time to listen to all members of staff.

The GP did have a system in place to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The GP did not, however, have systems in place to ensure that all issues reported were always recorded, for example:

- Not all staff were aware of their responsibility to report significant events or complaints. However, when the GP was made aware of a significant event or complaint it was investigated and dealt with in line with the practice policy. The practice gave affected people reasonable support, truthful information and a written apology.
- Discussions around patient complaints and significant events were dealt with informally, with no records being maintained of discussions between the practice and patients, analysis of these complaints/incidents or improvements implemented as a result of these complaints. There was no system to share this information and any learning with staff members not in attendance at meetings.
- The practice did not hold regular governance meetings, complaints and significant events were discussed at ad hoc meetings. No records were maintained of discussions taking place during these meetings. There was also no evidence of any system to feedback to staff not involved in these ad hoc meetings.

# Are services well-led?

Inadequate

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

**There was a leadership structure in place and staff received some support from management**

- Non-clinical staff told us they had not received regular performance reviews and did not have clear objectives; however, they showed awareness of their individual roles and responsibilities.
- Staff said they felt respected, valued and supported by the GP in the practice.

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

The practice collected feedback from patients and staff, for example:

- The GP had gathered feedback from staff generally through ad hoc staff meetings and discussion; however, there was no written record of these meetings or discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the GP.
- The GP did gather feedback from patients through the patient participation group (PPG), as there was an active PPG. For example, the GP updated their telephone system to accommodate three extra telephone lines.

**Continuous improvement**

There was little focus on continuous learning and improvement within the practice, however, a consulting room has been given to the local counselling services, used by young and working patients.

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<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>The registered person did not have processes in place for analysing significant events, incidents and near misses.<br>The registered person did not have a defibrillator available at the practice and had not completed a risk assessment to indicate they had assessed the risks this may present to patients.<br>The registered person did not ensure that appropriate risk assessments were available.<br>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**How the regulation was not being met:**<br>The provider could not demonstrate that non-clinical staff were trained to deal with significant events, incidents and near misses, fire safety and health and safety.<br>The provider had not ensured that there was an effective process to ensure that yearly appraisals were performed for all practice staff. |

This section is primarily information for the provider

# Requirement notices

This was in breach of regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**How the regulation was not being met:**<br>The provider had not ensured that all the necessary recruitment checks were undertaken prior to employing staff including Disclosure and Barring Service (DBS) checks and maintaining summaries of discussions taking place during interviews.<br>This was in breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |