Dr Muhammad Shahzad

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Muhammad Shahzad. Overall, the practice is rated as Good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- There was evidence that where patient outcomes were below the national average, the practice had taken steps to improve.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- Patients we spoke with 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.
- Home visits were available to patients of all age groups who had clinical needs which resulted in difficulty attending the practice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Although the practice had processes in place to support carers, less than 1% of carers were registered with the practice.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour.

The areas where the provider should make improvement are:

- Continue to monitor and improve outcomes for patients with diabetes with abnormal average blood sugar levels.

Summary of findings

- Monitor and consider ways to improve immunisation rates in under 5's.
- Monitor and consider ways to improve the uptake rates of national screening programmes for bowel and breast cancer.
- Review the national GP patient survey scores with the aim of improving patient satisfaction scores on nurses' giving patients enough time.
- Proactively identify patients who are carers.

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?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were mixed when compared to the national average. There was evidence that where patient outcomes were below the national average, the practice had taken steps to improve.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patient satisfaction scores were similar to the CCG and national averages for several aspects of care.

Summary of findings

- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had a smartphone application system called 'Patient access' containing lots of information regarding services and was available for patients to download and navigate.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, they discontinued their half-day opening hours on Wednesdays to open until 6.30 pm in order to cater for patients who had difficulty accessing the service on that day.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with 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.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mostly higher than local and national averages.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from one example reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.

Summary of findings

- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews, attended staff meetings and training opportunities.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group (PPG).
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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

Good

The practice is rated as good for the care of older people.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. For example, they were referred to a virtual ward where members of the multidisciplinary team gave their input in trying to support the patients care and treatment.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for some disease indicators such as diabetes were mixed when compared to the CCG and national averages. However, where patient outcomes were below the national average, the practice took steps to improve.
- The practice nurse specialised in diabetes management and a community diabetes nurse also carried out clinics at the practice.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.

Summary of findings

- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those 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

Good

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of antenatal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- Immunisation uptake rates for the standard childhood immunisations were mostly below average when compared to CCG and national averages. The practice told us they had a high transitory population which affected the uptake rate.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and a discontinuation of Wednesday surgery half days.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. They had recently signed up to the Skype video calling service to enable young people to access the GP.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding 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)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia. The mental health nurse carried out regular patient reviews in the practice resulting in good patient outcomes. For example, 100% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, which was higher than the CCG and national average.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs. Staff had attended dementia awareness training.
- The practice had a system in place to text and call to remind both vulnerable and mental health patients of their appointment especially with services like the dietitian. These patients were offered double appointments.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. A total of 373 survey forms were distributed and 103 were returned. This represented 4% of the practice's patient list.

- 84% of patients described the overall experience of this GP practice as good compared with the CCG average of 81% and the national average of 85%.
- 80% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 76% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 73% and the national average of 77%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 43 comment cards, all of which were positive about the standard of care received. Patients felt the practice provided an excellent service and staff were kind, caring and listened to their needs. They were happy with the new premises although two of the comment cards highlighted issues with parking, staff attitude and a cancelled appointment.

We spoke with one patient during the inspection who said they were satisfied with the care they received and thought staff were approachable, committed and caring. Friends and Family test results from April 2017 to August 2017 showed that 114 out of 125 patients who undertook the test were likely to recommend the practice to friends and families.

Dr Muhammad Shahzad

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Muhammad Shahzad

Dr Muhammad Shahzad also known as Zain Medical Centre located in Middlesex, holds a General Medical Services (GMS) contract, and is commissioned by NHS England, London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury, maternity and midwifery services and surgical procedures.

The practice is staffed by a senior male GP who provides nine sessions a week and a female locum GP who provides one session a week, as well as one part-time nurse who works 12 hours a week and a locum nurse who works five hours a week. The practice is also staffed by a practice manager who works 30 hours a week and four part-time receptionists. The practice is a teaching practice for medical students from Kings College London.

The practice is open between 8.30am and 6.30pm on Monday, Tuesday, Thursday and Friday and between 8.30am and 6pm on Wednesday. Appointments are from 9am to 1pm every morning and 4pm to 6.30pm on Monday, Tuesday, Thursday and Friday as well as 4pm to 6pm on Wednesday. Extended hours appointments are offered on Tuesday between 6.30pm and 7.30pm. Outside of these hours, the answerphone advises patients of the number of their out of hours provider, Care UK.

The practice has a list size of 2,700 patients and provides a wide range of services including a monthly in-house dietitian, phlebotomy, spirometry, child health surveillance, Yellow fever travel vaccinations, cervical screening, antenatal and postnatal care, chronic disease management and ECG monitoring.

The practice is located in a demographically diverse area, with a largely Asian and Eastern European population and a higher than average number of patients who do not speak English as a first language. The practice has a higher proportion than average of young people aged between 20 to 34 years of age.

On 8 September 2017, the practice relocated to new premises at Edgware Community hospital, Brunt Oak, Edgware, Middlesex, HA8 0AD from their old location at 122 Turner Road, Edgware, Harrow, HA8 6BH. The new location at Edgware Community hospital was leased to the practice by the hospital trust and the hospital is responsible for the day to day management of the practice premises. The practice is located on the ground floor, access is via the main hospital reception entrance and it is signposted.

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. We carried out an announced visit on 26 September 2017. During our visit we:

- Spoke with a range of staff including the senior GP, practice manager, practice nurse and one receptionist.
- We spoke with a patient who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 living 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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form 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).
- From the sample of three documented examples we reviewed, we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a child had been wrongly booked for a pre-school booster. When the nurse checked the records during their appointment, the child was not due an injection for another four months. The parents received an apology and this was discussed at a practice meeting. The practice made changes to ensure that the reception staff were aware of the immunisation schedule by creating an immunisation chart, kept at the reception desk for staff to refer to when booking children for their vaccination appointments.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had all received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three.
- 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 and had received a Disclosure and Barring Service (DBS) check. (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. There were cleaning schedules and monitoring systems in place.
- Two of the practice nurses were the infection prevention and control (IPC) clinical leads who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high-risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure

prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

We reviewed two personnel files for newly recruited staff members and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- Although the practice was renting their premises from the hospital, the hospital would normally carry out a fire and health and safety risk assessment; however, the practice had carried out their own fire and health and safety risk assessments when they moved into the new premises and shared the findings with the hospital.
- The practice carried out regular fire drills and there were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments carried out by the hospital 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. For example, locums were used to provide GP and nurse cover and the reception staff were rotated to ensure two staff covered the reception desk at all times.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which 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 had a defibrillator available on the premises and oxygen 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 comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (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). The most recent published results were 92% of the total number of points available compared with the clinical commissioning group (CCG) and national averages of 95%.

The overall practice exception rate for the practice was 7%, comparable to the CCG and national averages of 6%. The overall average of exception rates for some clinical domains were higher than the CCG or national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example:

- The overall exception rate for Atrial Fibrillation (AF) for those with a stroke risk score of two and above and currently treated with anti-coagulation therapy was 14%, compared to the CCG average of 8% and national average of 7%. The practice was aware of this and had subsequently identified that of the four practice patients diagnosed with AF at the time of the inspection, three had received a risk score. Before the inspection, the remaining patient had been risk scored and commenced on anti-coagulation therapy.

QOF Data from 2015/16 showed:

- Performance for diabetes related indicators was mixed when compared to the CCG and national averages. For example, the percentage of patients with diabetes on the register who had normal blood pressure levels was 91%, which was higher than the CCG average of 75% and national average of 78%.
- However, the percentage of patients with diabetes on the register, who had normal average blood sugar levels, was 58%, which was lower than the CCG and national average of 78%. The practice were aware of this and had carried out an audit which identified that there was poor compliance with mostly Gujarati speaking patients who had difficulty engaging with the practice and being involved in their care. The practice took steps together with the patient participation group (PPG) to find a diabetes champion for this population group who would invite them to biweekly talks on managing their diabetes.
- Performance for mental health related indicators was similar to the CCG and national averages. For example, the percentage of patients with mental health conditions who had a comprehensive agreed care plan was 95%, compared to the CCG average of 91% and national average of 89%.
- The percentage of patients with dementia who had received a face-to-face review in the last 12 months was 100%, when compared to the CCG average of 87% and national average of 84%.

There was evidence of quality improvement including clinical audit:

- There had been three clinical audits commenced in the last two years, one of these was a completed audit where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, they undertook a diabetes audit after their QOF indicators showed that they were below average for average blood sugar levels in diabetic patients. All 185 patients on the diabetes register were reviewed and an assessment was made of whether patients with abnormal average blood sugar levels had any intervention in the last six months, as well as to assess the reason for the abnormal levels.

Good

Are services effective?

(for example, treatment is effective)

- Results showed that 60 patients with type two diabetes had abnormal blood sugar levels despite intervention in the last six months with either the GP or the diabetic specialist nurse. The main factor identified for poor control was non-compliance with medication, attending appointments and patient management of insulin use. As a result of the audit, the practice worked together with the PPG to nominate a diabetes champion who spoke Gujarati, which the audit had identified as a population group experiencing particularly poor outcomes. Once identified, the practice would arrange bi-weekly evening talks for these patients to attend and help them engage and be involved in their care. In order to reduce non-attendance at appointments, patients were booked for their next appointment at consultation, and reception staff called patients a day before their appointment. At the time of inspection, a re-audit had not been undertaken and was due in three months.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions such as diabetes and asthma.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which 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, attending training and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision, facilitation, and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of four documented examples we reviewed we found that 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. Information was shared between services, with patients' consent, using a shared care record. Meetings usually took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. The practice told us that regular multidisciplinary meetings had been temporarily disrupted in the previous month due to their relocation and further meetings were being scheduled for the future.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

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.

Good

Are services effective?

(for example, treatment is effective)

- 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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the CCG average of 77% and the national average of 81%. There were failsafe systems 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. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring that a female sample taker was available and providing information in different languages.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. QOF data showed the uptake rate for bowel cancer screening in the last six months for persons aged 60-69 was 45% when compared to the CCG average of 49% and national average of 56%.

The uptake rate for breast cancer screening for women aged between 50-70 in the last six months was 40%, when compared to the CCG average of 72% and national average of 76%

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to one year olds were mostly above CCG and national averages. For example, the immunisation uptake rate for under one's was 93%, higher than the CCG average of 90%. However, the uptake rate for vaccines given to children aged between two and five years old was lower than CCG/national averages. For example, they ranged between 75% and 87%, lower than the CCG average which ranged between 83% and 91% and national average which ranged between 88% and 94%. The practice were aware of this and said that this was due to their high numbers of transitory populations who made up 38% of the practice, whose children had already received their immunisations by the time they registered with the practice, impacting the uptake rate.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection, we observed that members of staff were courteous and very 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 43 comment cards we received were positive about the standard of care received. Patients felt the practice provided an excellent service and staff were kind, caring and listened to their needs.

We spoke with one patient who was also a 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. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients said the GP was good at listening to them, similar to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 86%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 86%.
- 92% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 91%.
- 82% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 96% of patients said they had confidence and trust in the last nurse they saw, similar to the CCG average of 96% and the national average of 97%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared with the CCG average of 84% and the national average of 87%.

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.

Children and young people were treated in an age-appropriate way and recognised as individuals. For example, patients aged between 15 and 16 were able to book appointments on their own to see the GP or nurse for sexual health advice. Additionally, the practice had recently signed up to trial a Skype service with video recording for young patients to access the GP.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

Good

Are services caring?

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG and national averages of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care, similar to the CCG average of 79% and compared to the national average of 82%.
- 85% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 90%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw a noticeboard in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff that might be able to support them. For example, staff spoke Arabic, Urdu, Hindi, Punjabi, Gujarati, Romanian and Polish languages.
- Information leaflets were available in easy read format and health promotion television screen was available in the waiting area.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.
- The practice had a smartphone application system called 'Patient access' containing lots of information regarding services and was available for patients to download and navigate.

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. Support for isolated or housebound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 20 patients as carers (Less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. All carers were offered timely and appropriate support; for example, the practice had a carers alert system in place and they received same day appointments. All clinical and non-clinical practice staff had attended carers awareness course which helped them identify the needs of carers looking after elderly and patients with long-term conditions.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was followed either by a patient consultation at a flexible time and location to meet the family's needs 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 understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Tuesday evening until 7.30pm for working patients who could not attend during normal opening hours. They had also discontinued their half-day opening hours on Wednesday to open until 6.30 pm in order to cater for patients who had difficulty accessing the service on that day.
- There were longer appointments available for patients with a learning disability and mental health problems. Double appointments were also offered on request for all other population groups.
- Home visits were available to patients of all age groups who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children, carers, vulnerable patients and those patients with medical problems that require same day consultation.
- Patients were able to book their appointments online. Telephone appointments were offered.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS and the practice was a Yellow Fever centre. All other private vaccine requests were referred to other clinics.
- There were accessible facilities, which included a hearing loop, baby changing facilities, wheelchair access and a ramp available as well as interpretation services.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Access to the service

The practice was open between 8.30am and 6.30pm on Monday, Tuesday, Thursday and Friday and between 8.30am and 6pm on Wednesday. Appointments were from 9am to 1pm every morning and 4pm to 6.30pm on Monday, Tuesday, Thursday and Friday as well as 4pm to 6pm on Wednesday. Extended hours appointments were offered on Tuesday between 6.30pm and 7.30pm. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them. We saw evidence that appointment availability for patients ranged from the same day to two days wait.

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

- 78% of patients were satisfied with the practice's opening hours, similar to the clinical commissioning group (CCG) average of 78% and comparable to the national average of 80%.
- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 64% and the national average of 71%.
- 81% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 84%.
- 80% of patients said their last appointment was convenient compared with the CCG average of 73% and the national average of 81%.
- 80% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 73% of patients said they do not normally have to wait too long to be seen compared with the CCG average of 44% and the national average of 58%.

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

The practice had a system to assess:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was done by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system 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. For example, a complaints leaflet and a summary leaflet was available. .

The practice had only received one verbal complaint in the last 12 months regarding a screening test that a patient had requested that did not take place as it was not yet due. We saw evidence that this complaint was satisfactorily handled and there was openness and transparency in dealing with the complaint. An apology was offered to the patient and the complaint was discussed in a team meeting.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood their values of 'Sincerity, Honesty and Support'.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, the practice nurses had roles in infection control and the GP was the lead in safeguarding.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly. We found the practice had updated their policies to include the new premises.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice was renting their premises from the hospital that would normally carry out a fire, health, and safety risk assessments; however, the practice had carried out their own risk assessments when they moved into the new premises and shared their findings with the hospital.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection, the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The Lead GP was the clinical director for the local clinical commissioning group (CCG) as well as an examiner for medical students. The practice also had a buddy system in place with another local practice and this enabled both practices to support each other, including the practice manager who also had a buddy practice manager from that practice.

The provider was aware of and had systems 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). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of three documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses, diabetes specialist nurses and social workers to monitor vulnerable patients. GPs met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.

Are services well-led?

Good

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the PPG and through surveys and complaints received. The PPG met regularly and they were involved in the consultation process regarding the practice move to the new premises. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team. For example, they suggested a noticeboard in different languages at the reception desk.
- the NHS Friends and Family test, complaints and compliments received.
- staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff suggested a register of deaths to be kept at the reception desk so all staff were kept aware of when bereavement occurred. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, they had recently signed up to trial a Skype service with video recording for young patients to access the GP.