# Dr Jandu and Partners

## Quality Report

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Date of inspection visit: 26 November 2014
Date of publication: 19/03/2015

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

## Ratings

| | |
|---|---|
| Overall rating for this service | 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 inspected Dr Jandu and Partners at Frizinghall Medical Centre on the 26th November 2014 as part of our new comprehensive inspection programme. Our inspection team was led by a CQC Inspector and included a GP specialist advisor and an Expert by Experience.

We have rated the practice as good.

Our key findings were as follows:

- There were comprehensive systems to keep people safe. The whole practice team was engaged in reviewing and improving safety and safeguarding systems. Innovation was encouraged to achieve sustained improvements in safety.
- There was a holistic approach to assessing, planning and delivering care and treatment. Innovative approaches to care and how it was delivered were encouraged.
- Staff recognised and respected the totality of patient's needs, including their personal, cultural and social needs.
- There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs. This included people who were in vulnerable circumstances or who had complex needs.
- Patients could access appointments and services in a way and at a time that suited them.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture.

We saw two areas of outstanding practice:

- Children with very complex needs were assigned a named GP and a named receptionist whose role was to assist with liaison with other services.

# Summary of findings

- The effectiveness of the practice's approach to identifying, following up and managing serious illnesses, including cancer referrals, was evident from local performance data which showed it was significantly better than most other practices.

However, there was also an area of practice where the provider needs to make improvements.

- The provider should ensure there is a system to check that patient safety alerts have been acted upon.

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. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used opportunities to learn from peer reviews, internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute of Health and Care Excellence NICE guidelines and locally agreed guidelines. We also saw evidence to confirm that these guidelines were influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the same Clinical Commissioning Group.

**Are services caring?**

Good

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

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

Good

The practice is rated as good for providing responsive services. The staff acted on suggestions for improvements and changed the way they delivered services in response to feedback. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with their preferred GP. The practice had good facilities and was well equipped

# Summary of findings

to treat patients and meet their needs. Information about how to complain was available and the practice responded quickly when issues were 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 with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice was aware of future pressures which could affect the quality of the service and was proactive in identifying ways to manage their impact. There was a high level of constructive engagement with staff and a high level of staff satisfaction.

# 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 was rated as good for the care of older patients. Staff were able to recognise signs of abuse in older patients and knew how to escalate or refer these concerns. Home visits for influenza flu vaccinations were arranged for older patients who found it difficult to attend the practice. Carer status was regularly checked to ensure their needs and the needs of the patient were being met. Information on healthy living and self-care was available on the practice website and leaflets in the surgery. Patients aged over 75 had a named GP. District Nurses and Palliative Care Nurses were involved in practice meetings to ensure that care for patients at the end of their lives was coordinated. Patients at high risk of admission to hospital were provided with a priority access telephone number. The practice had a good working relationship with local care homes.

**People with long term conditions**

Good

The practice was rated as good for the care of patients with long term conditions. Nurse led chronic disease management clinics were available for patients with diabetes, coronary heart disease, chronic obstructive pulmonary disease or asthma. Facilities were available for the routine on-site testing of; lung capacity, ECG, average blood glucose levels and 24hour blood pressure measurements. A recall system had been introduced to identify and combine regular tests which were required by people with long term conditions. Information was available on the practice website with many links to advice and organisations offering support.

**Families, children and young people**

Good

The practice was rated good for the care of families, children and young patients. All staff had received child safeguarding training appropriate to their role. Children with complex needs had a named GP and receptionist whose role was to ensure effective liaison with other health and social care services and provide rapid access for help when needed. Children and young people were treated appropriately and their consent to treatment obtained in accordance with current legal guidance. Antenatal, childhood immunisation clinics and mother and baby clinics were available. Contraception advice, including access to emergency contraception, was available at the practice. Women were supported and encouraged to participate in regular cervical screening.

# Summary of findings

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

Good

The practice was rated as good for the care of working age patients. A self-care event and clinics were provided to promote good health and wellbeing. Emergency appointments, telephone consultations and an extra evening clinic from 6.30pm until 8.00pm were available to accommodate people working between the hours of 9am and 5pm. Repeat prescription requests were available in person and on-line and were ready to collect within 48 hours.

**People whose circumstances may make them vulnerable**

Good

The practice was rated as good for the care of people living in vulnerable circumstances. Staff understood how to identify and safeguard vulnerable patients. Staff were aware of their responsibilities to act on safeguarding concerns and there was evidence of actions taken to safeguard patients. The staff knew the practice patients well and were able to identify a person at risk. We heard of three examples where staff had intervened to support a person in vulnerable circumstances, providing help or working with other health and social care professionals to assist the patient. The staff worked closely with families and carers of patients with mental health concerns or learning difficulties, community staff, care homes and other local practices to improve the care and treatment of patients

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

Good

The practice was rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice worked proactively with other health and social care services. Dementia screening and preparatory assessments were carried out for patients referred to the memory clinic. Seven day medicine dossett boxes were available for certain patients, including those with dementia. Physical health checks, including checks on tobacco and alcohol usage were available for patients with long term mental health concerns. Information and signposting to other support services was available on the practice website and in the surgery.

# Summary of findings

## What people who use the service say

During our visit we spoke with four patients and reviewed 11 completed CQC comment cards and one letter. Patients were complimentary about the staff and the care and treatment they received. They felt they were treated with courtesy and respect and kept informed about their diagnosis and treatment. The most recent (December 2014) national general practice survey found that of the 89 patients who responded:-

- 93% had confidence and trust in the last nurse they saw or spoke to (CCG average 81%).
- 91% had confidence and trust in the last GP they saw or spoke to (CCG average 87%).
- 90% said the last appointment they got was convenient (CCG Average 86%).
- 87% said the last nurse they saw or spoke to was good at giving them enough time (CCG Average 74%).
- 76% said they usually wait 15 minutes or less after their appointment time to be seen (CCG Average 61%).
- 75% usually got to see their preferred GP (CCG average 43%).

## Areas for improvement

**Action the service SHOULD take to improve**

NHS safety alerts were logged and where necessary redirected to an appropriate member of staff as a 'task' for action. However, there was no formalised system to confirm that the required actions had been taken.

## Outstanding practice

- Children with very complex needs were assigned a named GP and a named receptionist whose role was to assist with liaison with other services.
- The effectiveness of the practice's approach to identifying, following up and managing serious illnesses, including cancer referrals, was evident from local performance data which showed it was significantly better than most other practices.

# Dr Jandu and Partners

**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 and an Expert by Experience.

## Background to Dr Jandu and Partners

Dr Jandu and Partners, also known as Frizinghall Medical Centre, is located approximately three miles from Bradford City Centre. The practice provides primary medical care services for approximately 3500 patients under the terms of a Personal Medical Services contract.

The practice catchment area is classed as within the 20% most deprived areas in England. There are a higher proportion of patients aged under 18 years (27%) and a lower proportion of patients aged over 65 years (9%) compared to the averages (21% and 16% respectively) for all GP practices in England. The results of the most recent (July 2014) National Patient Survey and the practice's own survey (September 2014) indicate high levels of satisfaction with the staff and availability of appointments.

There are three permanent doctors at the practice, two male and one female. They are supported by a practice nurse, phlebotomists and an experienced administrative team. The practice is open from 8.00am until 6.00pm each weekday with the exception of Mondays when an evening surgery is also available until 8.15pm. As part of the local winter initiative the practice is open for emergency appointments between 9.00am and 11.30am on Saturday mornings from 1November 2014 until 28 March 2015.

Antenatal, health visitor, child health and baby clinics are run each week. The practice carries out minor surgical procedures and the treatment of minor injuries. Other services provided include, phlebotomy (taking of blood samples), postoperative wound care, hormone implants, emergency contraception and near patient testing for patients under the joint care of a GP and hospital consultant. Out of hours care is provided by Bradford & Airedale NHS Teaching Trust.

The practice is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services surgical procedures and the treatment of disease, disorder or injury from Frizinghall Medical Centre, 274 Keighley Road, Bradford, West Yorkshire, BD9 4LH.

## Why we carried out this inspection

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

## How we carried out this inspection

Before visiting, we reviewed information that we hold about the practice. We also asked Bradford Clinical Commissioning Group (CCG) and NHS England to share what they knew. We carried out an announced visit on 26

# Detailed findings

November 2014. During our visit we spoke with two of the GPs, the practice manager and four other members of the administration team. We also spoke with four patients who used the service and reviewed 11 comment cards where patients 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Good

# Are services safe?

## Our findings

Safe track record

The practice routinely monitored patient and performance information, such as; significant incidents, audit reports, safeguarding concerns, complaints, hospital episode statistics and Quality Outcome Framework (QOF) indicators, to identify risks and improve patient safety. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents or near misses. NHS safety alerts were logged and where necessary redirected to an appropriate member of staff as a 'task' for action. However, there was no formalised system to confirm that the required actions had been taken.

Learning and improvement from safety incidents

The Practice had systems in place for reporting, recording and monitoring significant events. Significant incident report forms were accessible to all staff. Practice meeting records showed that these were discussed and acted upon by the staff. For example, following one incident improvements had been made to the accessibility of emergency equipment.

Reliable safety systems and processes including safeguarding

One of the practice GPs had been appointed lead clinician responsible for safeguarding matters. All the staff had completed safeguarding training appropriate to their role, including Level 3 for the GP safeguarding lead. Information about safeguarding procedures was displayed in the reception area, consulting and treatment rooms. Staff were aware of their responsibilities to act on safeguarding concerns and there was evidence of actions taken to safeguard patients. We were provided with details of actions taken by the staff in response to concerns involving, children young adults and the welfare of older people.

There was an annual programme of checks to assess risks to the health and safety of patients, staff and visitors. The programme included checks on each room at the practice, the potential risk and control measures. Annual assessments were also carried out on the safety of fire and evacuation procedures, portable electrical appliances and mains water supply outlets.

Medicines management

Medicines were stored securely in key locked medicine refrigerators. Access was restricted to authorised staff. The practice policy for ensuring that medicines were kept at the required temperatures included details of the action to take in the event of a potential power or equipment failure. Guidance was also displayed on the medicines refrigerator door. Daily checks were made of the refrigerator internal temperature and records kept to confirm there had been no break in the cold chain. Processes were in place to check that medicines, including emergency medicines, had not exceeded their expiry date and were suitable for use. Expired and/or unwanted medicines were disposed of in line with waste disposal regulations.

Patients were able to request repeat medicines; in person at the surgery, by fax or on-line. There were clear procedures for the authorisation of repeat medicines. Each request was reviewed by a GP, including checks on the patient's details, blood test results, whether the patient had been seen by a nurse and whether a medication review appointment was required. Special arrangements were in place for some vulnerable patients. For example, some patients were provided with seven day supplies of medicine in dossett boxes and/or their carer contacted to ensure they were taking their medication as prescribed. Where appropriate issues with compliance were flagged up and discussed with the patient or their carer.

Cleanliness and infection control

The practice premises were visibly clean and tidy. There was a nominated lead for cleanliness and infection control. Staff had received infection control training. Records of staff immunisation status were available. Hand washing materials, personal protective equipment and clinical waste bins were provided. Clinical supplies were neatly stored and accessible. Surface disinfection wipes, replaceable paper privacy curtains and examination couch covers were in use.

The practice had recently completed a full externally assessed infection control audit, achieving an overall score of 95%. Some minor issues, such as replacement of carpets and sinks, had been identified. The audit findings had been discussed in practice meetings and remedial actions agreed. The practice had also appointed a new cleaning contractor. Colour coded cleaning equipment was supplied and appropriately stored ready for use. Cleaning checklists were provided for the cleaning staff to follow, however, these lacked detail and had not been signed by the cleaner

Good

# Are services safe?

responsible. The practice were aware of these shortcomings and was actively seeking improvements in the standard of recording and auditing of routine cleaning procedures.

Equipment

Equipment was appropriately checked and maintained. There was an annual schedule for the maintenance and calibration of equipment, including clinical, electrical and safety equipment, used at the practice. The schedule included details of test requirements, service agent contact telephone numbers and the name of the member of staff responsible.

Staffing and recruitment

The practice recruitment policy set out the procedure and standards required for the selection and appointment of new staff. Individual staff personnel records, for the two most recently appointed staff, included evidence of appropriate recruitment checks prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). Checks carried out for long serving staff had also been reviewed and where appropriate applications had been made for DBS checks.

Monitoring safety and responding to risk

Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment. Demand for appointments was continuously monitored. Where necessary, reception staff were able request additional GP appointments to accommodate urgent requests. Where increases in demand were identified, for example following infectious disease outbreaks, additional clinical sessions were added to the normal weekly pattern to ensure that all patients needing to be seen were able to obtain an appointment.

Arrangements to deal with emergencies and major incidents

Staff were familiar with medical emergency and fire evacuation procedures, the location of emergency equipment and alarm buttons. Fire evacuation procedures were practiced and their effectiveness monitored. Staff discussed improvement to emergency procedures and there were records which described an emergency incident, the staff response and agreed improvement actions.

# Are services effective?

(for example, treatment is effective)

## Our findings

Effective needs assessment

The practice participated in a number of quality and innovation schemes as part of the NHS Commissioning for Quality and Innovation (CQUIN) framework, including; asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), chronic kidney disease (CKD) and diabetes. The key aim of these schemes was to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management.

NHS Commissioning Support Unit performance data for 2013-2014 showed that the practice was performing better than the average for all practices in the Clinical Commissioning Group (CCG) area. For example; the proportion of first outpatient appointments, non-elective in-patient activity and accident and emergency attendances were all lower (8%, 9% and 11% lower respectively) than the CCG average.

The prevalence of patients with cancer was similar to average for all practices in England. However, practice data showed that the proportion of patients receiving a positive diagnosis (26%) following an urgent (two-week) referral was over double the national average (11%). Similarly the proportion of patients (71%) identified through managed referrals i.e. after being referred by a GP as opposed to diagnosed following an emergency attendance at A&E, was approximately one and a half times the national average (49%).

Management, monitoring and improving outcomes for people

Significant incidents were discussed each week. Appropriate staff had been involved in debriefing sessions and asked to consider how the incident occurred and was dealt with, including suggestions for improvement. The practice continually monitored information about patient outcomes and the quality of care using a variety of performance and benchmarking tools, including local Commissioning Support Unit reports. The information was discussed within the practice and where necessary improvement actions agreed and implemented. We were shown how data from the Primary Care Web Tool was routinely used to assess performance and follow up 'trigger' points or data which indicated that there was a significant difference in the practice's performance compared to other practices.

The practice had joined a local enhanced integrated care scheme to peer review anonymised high risk or complex patients. The practices met each month together with other health and social care professionals to discuss care and treatment options, share good practice and improve communications between professional and patients.

The practice had a system in place for completing clinical audit cycles. We looked at two of clinical audits, vitamin D testing and prescribing and the use of ECG following diagnosis of hypertension. In both cases improvements in diagnosis and treatment were seen between 2012 and 2013.

Effective staffing

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning and development needs of staff were identified and training provided. Staff were supported to maintain and further develop their professional skills and experience. Detailed training records were maintained for all staff and showed the areas of training completed, the dates and individual assessment scores.

Working with colleagues and other services

Paper and electronic records relating to the care of patients were well managed. Staff could easily access the information they needed to assess, plan and deliver care to patients in a timely way. This included information shared between hospitals and out-of-hours services. Information received by the practice was checked by one of the GPs and any actions, such as changes to prescribed medication, were followed up and the patient informed. In certain cases, for example; children, frail elderly or vulnerable patients, the practice contacted their parent or carer. A similar system was in place to review hospital discharge letters.

There was a clear audit record for information received from other services. Test results, hospital letters, out of hours and emergency hospital attendance reports were checked by the duty GP within 24 hours and added to the

# Are services effective?

## (for example, treatment is effective)

patient's clinical record. Information requiring further action, such as a home visit, was electronically 'tasked' using the practice clinical IT system to the appropriate member of staff.

Staff worked collaboratively to understand and meet the needs of patients. For example, the planning of influenza clinics involved the whole staff team. Changes in demand for appointments were responded to promptly and where appropriate extra sessions added to the normal weekly schedule. District Nurses and Palliative Care Nurses were involved in surgery meetings to ensure that care for patients at the end of their lives was co-ordinated.

Information sharing

Staff routinely checked whether patients were due any tests, immunisations or reviews when they booked an appointment or visited the practice. If appropriate an electronic task was sent to the patient's GP prior to their appointment time to ensure that any outstanding tests were completed. Where necessary there were procedures in place to book an additional appointment with the practice nurse on the same day. Vulnerable patients, for example those with learning difficulties, were offered extended appointments and encouraged to attend with their carer.

Consent to care and treatment

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. For example we were told of a patient with mental health problems who had been advised that surgery was necessary. However, the patient was unwilling to give their consent. An Independent Mental Capacity Advocate (IMCA) had been appointed at the request of the practice and a mental capacity assessment carried out. Good practice and legal guidance was also followed in relation to consent by children to medical examination and treatment or the provision of contraception, sometimes referred to as Gillick Competence and Fraser Guidelines.

Health promotion and prevention

Staff supported people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was used to do so. There was joint working with other local services to support patients improve their health. A 'self-care' event had been organised and attended by approximately 20 patients registered with the practice. The practice had introduced screening for diabetes, cardiovascular checks for patients aged 40 -70 and dementia screening for those over 75 years of age. New patients were offered health checks. Eligible female patients were encouraged to discuss cervical screening with the practice nurse. Patients with learning difficulties or severe mental health concerns were offered annual physical health checks. Information was available on the practice website with many links to advice and organisations offering support.

Patients were sent text messages to remind them of their appointments. Patients who failed to attend health checks, screening or immunisation appointments were followed up. A register was kept of patients who had informed the practice that they had caring responsibilities. These patients were offered additional help with their appointments, for example by arranging home visits and liaising with the local authority social services teams.

# Are services caring?

## Our findings

Respect, dignity, compassion and empathy

Feedback from patients was positive. We reviewed the most recent patient satisfaction scores based on responses to the national GP patient survey. The results were above the average for all practices in the Clinical Commissioning Group (CCG) area. For example; 87% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG average 73%), 76% said they usually waited 15 minutes or less after their appointment time to be seen (CCG average 61%) and 75% with a preferred GP usually got to see or speak to that GP (CCG average 43%). These findings were supported by comments made by patients we spoke with during our inspection visit and the responses on CQC comment cards.

People's privacy and confidentiality was respected. Staff had undergone chaperone training. They were aware of how to support patients in ways which maintained their dignity during examinations. We were told of a situation in which a patient needed urgent treatment but was anxious about attending the practice. The staff reassured the patient and made an appointment at the end of the normal surgery when other patients or visitors were less likely to be present at the practice.

Staff recognised and respected patients' needs, including their personal, cultural and social needs. Links had been established with local third sector organisations which provided support for vulnerable groups, such as carers, people with learning disabilities or mental health concerns. We heard how the practice had supported new parents who were anxious about caring for their child and were contacting the practice and out of hours services several times a week. The parents, who had no local family support, were provided with an appointment with a health visitor and details of the local mother and toddler support group.

Care planning and involvement in decisions about care and treatment

Patients were encouraged to be partners in their care and in make decisions about their treatment. Information cards, promoting self-care and suggesting questions to ask the doctor were available for patients to use and keep. The practice website included information about long term conditions such as asthma and diabetes as well as general health advice for different population groups. Advice on the treatment of minor ailments was also included in the practice leaflet. Approximately 20 patients had attended a self-care event earlier in the month. The event included information about other organisations, such as Age Concern and the Alzheimer's Society, and services such as Pharmacy First to help people stay healthy during the winter.

Patients were communicated with and received information in ways that they understood. Staff at the practice spoke Urdu, Punjabi, Hindi and Mirpuri. One of the receptionists had trained as an interpreter. Where appropriate patients and carers were encouraged to become involved in decisions about their care. We were told about patients, particularly those of working age, who were recommended to look at specific websites relating to their condition. In other situations, patients were given full explanations during their appointments.

We also heard of examples of carers being involved in decisions and care planning. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 11 CQC comment cards we received on the day of our visit was very positive, including several references to the helpfulness of the staff and quality of the service. There was only one negative reference about not being listened to or feeling adequately involved.

Patient/carer support to cope emotionally with care and treatment

The practice was sensitive to and sought to accommodate cultural factors relating to care and treatment, for example completing death certificates promptly to enable burials to take place according religious practices. Patients and carers were offered emotional support and information to help them cope with their care and treatment. Carers or families recently bereaved were written to offering support and where appropriate counselling. Reception staff had bereavement advice leaflets which they could offer to

# Are services caring?

patients when appropriate. They offered relatives and carers appointments at the end of normal surgery times so they were not rushed and could spend time talking to the doctor.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Responding to and meeting people's needs

There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs. This included people who were in vulnerable circumstances or children with complex needs. Patients identified as at risk of an unplanned admission or a high use of emergency services were given priority access to appointments. We saw information compiled by the regional Commissioning Support Unit showing that non-elective inpatient appointments for the most recent period monitored (April 2013 to January 2014) were 9% lower than the CCG average. The proportion of practice patients attending Accident and Emergency facilities was 11% below the CCG average. Children with very complex needs was assigned a named GP and a named receptionist whose role was to assist with liaison with other services, such as the school nurse. In another case one of the GPs had raised concerns with the local adult services department about a frail elderly couple and requested an assessment of their social care needs.

During our visit we noted the staff were liaising with the community pharmacist and district nursing team to contact an elderly patient who had failed to collect their medication. We were also told how staff had helped one vulnerable patient to set up reminders on their mobile telephone to renew their fitness to work note (Fit Notes) so that they would not have their state benefits suspended.

Tackling inequity and promoting equality

Services were planned and delivered in a way that met the needs of the local population and reflected the importance of flexibility, choice and continuity of care. Interpreter services were available. Information about the role of NHS was published on the practice website. The information, which was available in 20 different languages, was aimed at newly-arrived patients to the UK including those seeking asylum, and covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register as a patient and how to access emergency services.

There was close working with local care homes, including provision of priority telephone numbers. Annual health checks and dementia screening were available at the practice, for example for those aged over 75 years, those with mental health concerns or a learning disability. Care and treatment of patients with learning disabilities was coordinated with family members or carers. Of the 33 patients on the practice's learning disability register, all those who were due for their annual health check had been seen and the practice was on target to complete the rest by the end of the year.

Patients with long term conditions had access to specialist asthma, COPD or diabetes clinics and six monthly medication reviews. Facilities were available at the practice to carry out routine spirometry, ECG and 24 hour blood pressure monitoring. The practice was also able to carry out tests of average blood sugar levels. This provided additional benefits for patients with diabetes and the management of diabetes-related complications.

Access to the service

Patients could access appointments and services in a way and at a time that suited them. Appointments were available at the practice or by telephone each weekday, with extended hours on Monday evenings. On-line facilities were available to book appointments or request repeat medication. Text messages were sent to remind patients of their appointment time. Requests for appointments were continually monitored. Where staff identified growing demand, for example as a result of an infectious outbreak, additional appointments or sessions were added to the normal weekly schedule to accommodate the extra demand.

Reception staff sought to meet the needs of patients as flexibly as possible. For example, trying to utilise daytime appointments for patients who were able to access them and prioritising early morning or late afternoon appointments for parents with school age children. Patients confirmed that the availability of appointments was good. They were able to obtain an appointment with a male or female GP. At 2.45pm on the afternoon of our visit were noted that urgent appointments were still available and the next bookable routine appointment was the following morning. We also observed a patient being told to come down to the surgery straight away and be seen by a doctor as an emergency, because they had telephoned the practice describing a potentially serious symptom.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Information about complaints procedure was available on the practice website and in the practice

# Are services responsive to people's needs?

## (for example, to feedback?)

leaflet. The practice manager was responsible for managing complaints and ensuring that an investigation was carried out when appropriate. The practice's complaints records included details of three complaints received in the previous year. The summaries included examples of the action taken, including face to face meetings with the complainant, a review of the complaint by the full staff team, a change in procedures and the issuing of an explanation and written apology.

# Are services well-led?

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

## Our findings

Vision and strategy

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to raise concerns. Staff said there was a focus on patient safety, improving the service and achieving best practice standards.

The practice was alert to future pressures and challenges and sought opportunities to ensure they remained at the forefront of innovation. For example facilities were available for some diagnostic tests to be carried out at the practice. Such tests, sometimes called 'near patient testing', can provide GPs with immediate information and change a patient's treatment immediately without having to wait for laboratory results and recall the patient for a further appointment.

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Governance arrangements

There was an effective governance framework, which focused on delivering good quality care. Structures, processes and systems of accountability, including joint working arrangements and shared services, were clearly set out, understood and effective. There were systems and procedures in place to monitor staff performance and the quality of the service. Staff were clear about their roles and responsibilities. There was a thorough understanding of performance, which included the views of staff and patients. A range of internal and external information sources were used to monitor performance and patient outcomes. All the staff knew how to access performance data and were encouraged to identify improvement actions which contributed to the development of the service.

Leadership, openness and transparency

The practice culture encouraged openness and was centred on the needs of patients. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. The practice participated in quality improvement schemes, worked with other health and social care organisations to share best practice and ensure a holist approach to care and treatment. The staff understood the challenges to maintaining good quality care.

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

The practice had tried a number of approaches, such as open meetings and surveys, to encourage patient participation and gather their views. Maintaining involvement had proved challenging and the practice had taken a more proactive approach. A patient participation lead had been appointed, as part of a Clinical Commissioning Group initiative, to encourage patients from differing social and cultural backgrounds to engage more actively in the development of the practice. As part of the process a patients survey had been carried out and new patients packs had been produced for different patient groups, for example those originating from East European countries. Information about patient participation was displayed on the practice notice board together with results of the practice survey and information about self-care and local support groups.

Management lead through learning and improvement

Staff said they were supported and encouraged to develop their knowledge and skills. Their training needs were discussed through supervision and appraisal. Staff files included appraisal records and training and development plans. Reviews of complaints and significant incidents were shared with staff at practice meetings to ensure the practice improved outcomes for patients.