# Dr Muhammad Adeel Iqbal

## 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

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## Overall summary

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

We carried out an announced comprehensive inspection at Dr Iqbal's at Kensington Street Health Centre

On 3rd February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action was taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice. The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.
- Evidence we reviewed demonstrated patients were satisfied with how they were treated and this was with compassion, dignity and respect. It also demonstrated the GPs were good at listening to patients and gave them enough time.
- The service was well led and there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice including:

- The practice opened on Saturday mornings during the winter months to help reduce hospital pressures.
- The practice had commissioned the Pharmacy First Scheme for minor ailments to ease patient access to

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appointments. (Patients who do not pay for their prescriptions can visit the pharmacy with specific symptoms, such as conjunctivitis, and be offered advice and appropriate medicines. This is a free service to these patients).

- The practice had also employed a pharmacist to see patients for minor ailments and give advice; the pharmacist then has access to appointments to refer patients to a GP.
- The practice was working with the local hospital to screen patients for Hepatitis B & C.
- The practice has put into place a patient involvement lead to help engage with patients at the practice.

However, there were also areas of practice where the provider needs to make improvements.

- Staff recruitment processes were not always in accordance with guidance and appropriate pre-employment checks were not always made.

**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 to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence on-going support for all staff.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information 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. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

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**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

**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 chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people 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. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

**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 the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

# Summary of findings

to ensure these were accessible, flexible and offered continuity of care. 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.

**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 with a learning disability. It had carried out annual health checks and offered longer appointments for this group of patients.

**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). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

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## What people who use the service say

In the most recent information from the GP Patient Survey 2014 NHS England 89% of patients described their overall experience of this surgery as good and 82% said that the last appointment they got was convenient.

We received 19 completed patient CQC comment cards and spoke with five patients on the day of our visit. Generally the comment cards were positive. Three of the cards stated they had to wait in line at the practice a long time to get an appointment, however they confirmed that they were seen the same day. Other comments said they got same day appointments and that it was a friendly and efficient service. The patients we spoke with were all positive and happy with the service they received.

## Areas for improvement

**Action the service SHOULD take to improve**

Staff recruitment processes were not always in accordance with guidance and appropriate pre-employment checks were not always made.

## Outstanding practice

- The practice opens on Saturday mornings during the winter months to help reduce hospital pressures.
- The practice had commissioned the Pharmacy First Scheme for minor ailments to ease patient access to appointments. (Patients who do not pay for their prescriptions can visit the pharmacy with specific symptoms, such as conjunctivitis, and be offered advice and appropriate medicines. This is a free service to these patients).
- The practice employs a pharmacist to see patients for minor ailments and advice; the pharmacist then had access to appointments to refer patients to see a GP where necessary.
- The practice was working in collaboration with the local hospital to screen patients for Hepatitis B & C.
- The practice had put into place a patient involvement lead to promote the practice and link with patients.

# Dr Muhammad Adeel Iqbal

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead inspector and included a SPA Specialist advisor GP and a second CQC inspector.

## Background to Dr Muhammad Adeel Iqbal

Dr Iqbal's practice is within the Kensington Street Health Centre located near to the centre of Bradford. The building is a purpose built building with good parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. It provides Primary Medical Services (PMS) for 5255 patients under a PMS contract with NHS England in the Bradford City Commissioning Group (CCG) area. The practice is in Girlington which is in a deprived area of Bradford.

The practice has two GP partners, one salaried GP and a locum GP (three male and one female). They also have an advanced nurse practioner, practice nurse, two healthcare assistants and an experienced administration and reception team. The reception team consists of one practice manager and nine reception and administrative staff.

The practice is open Monday to Friday from 8:30am to 6pm with extended opening hours on a Wednesday morning and late opening on a Monday evening. The practice offers Saturday morning openings as part of the winter pressures between 9 and 11:30am at the Little Horton Lane Medical Centre.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access the out of hour's provider service Local Care Direct on 111.

The practice population is made up of a predominately younger and working age population between the ages of 0- 49 years. Sixty three per cent of the patients have a long-standing health condition.

A wide range of practice nurse led clinics are available for patients at the practice. These include vaccinations and immunisations, cervical smears, family planning, spirometry, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease. The practice also holds clinics for smoking cessation and healthy living. Additionally within the same building patients can access health visitors, midwives, podiatry, dentist, and debt and benefits advice.

The practice has commissioned the Pharmacy First Scheme for minor ailments to ease patient access to appointments. They have also employed a pharmacist to support patients with minor ailments and advice.

The CQC intelligent monitoring placed the practice in band 4. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

# Detailed findings

## 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. This practice was part of a random selection of practices in the Bradford City CCG area.

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.

## How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 3 February 2015. During our visit we spoke with a range of staff including the practice manager, GPs, advanced nurse practioner, practice nurse, health care assistant and reception staff. We also spoke with five patients on the day.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 19 CQC comment cards where patients had shared their views and experiences of the service. We also reviewed records relating to the management of the service.

# Are services safe?

## Our findings

**Safe track record**

The practice had systems in place to monitor all aspects of patient safety. Information from the Quality and Outcomes Framework (QOF), a national incentive and reward scheme that helps practices to focus on better outcomes for patients, showed that in 2013-2014 the practice was appropriately identifying and reporting incidents. The practice had a rating of 95%. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

**Learning and improvement from safety incidents**

There were effective protocols used to scrutinise practice. The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 12 months. We saw incidents were discussed at weekly GP and monthly practice meetings. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a mistake had been made checking the identity of a patient, leading to a prescription being issued to the wrong patient. The error had been realised before any harm to the patient.

National patient safety alerts were disseminated to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Staff told us they felt confident in raising issues with the GPs and felt action would be taken. It was clear there was a culture of openness operating throughout the practice, which encouraged errors and 'near misses' to be reported. We saw where patients had been affected by something that had gone wrong, in line with practice policy; they were given an apology and informed of the actions taken.

**Reliable safety systems and processes including safeguarding**

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP for safeguarding. All GPs at the practice and staff had completed safeguarding training. We saw GPs and the advanced nurse practioner had the right training in place to support vulnerable patients. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. This helped to ensure the protection of children and vulnerable adults.

We confirmed staff used appropriate codes on their electronic case management system for children and vulnerable adults. This identified risks to these groups were known and reviewed. The system also flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer.

We saw that systems were in place to monitor babies and children; for instance, where patients failed to attend for childhood immunisations, or who had high levels of attendances at A&E. The practice identified and followed up children living in disadvantaged circumstances and who may be at risk, for example, children and young people who failed to attend appointments or clinics.

There were chaperone notices displayed on all consulting rooms doors and a chaperone policy in place (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). There was evidence of patients being offered chaperone services during consultation and treatment and staff had received appropriate guidance and training.

**Medicines management**

There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff. We saw

appropriate action had taken place when there had been a power failure overnight. Staff had contacted the manufacturers for advice, which they followed as safe storage had been compromised.

The amount of medicines stored within the practice was closely monitored and medicines were kept in a secure store with access by clinical staff only. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings where prescribing errors were reviewed. There were systems in place to ensure GPs and the pharmacist regularly monitored patients medication. Re- issuing of medication was closely monitored, with patients invited to book a 'medication review', where required. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent medical alert and what action had been taken.

The nurses and the health care assistant administered vaccines using Patient Group Directions(PGDs) produced in line with legal requirements and national guidance. We talked with staff who confirmed they had received appropriate training to administer vaccines. The data from 2013-14 NHS England showed 93% of children aged 5 years at the practice had received their vaccinations.

**Cleanliness and infection control**

We saw all areas throughout the practice were clean. We saw there were cleaning schedules in place and cleaning audit records were kept in each treatment room. We saw liquid soap and paper hand towels were available in treatment rooms and public areas. Notices about hand hygiene techniques were displayed in staff and patient toilets.

Patients we spoke with and responses from the CQC comment cards confirmed patients found the practice clean and had no concerns about cleanliness or infection control. Suitable arrangements were in place to help ensure the practice was cleaned to a satisfactory standard.

An infection control audit had recently been undertaken and recommendations were being actioned. There was a lead for infection control and staff had training in this area. We looked at the Infection Control Policy in place and noted it was up to date and regularly reviewed.

We confirmed Personal Protective Equipment (PPE) was easily accessible to all staff. Single use equipment was available and safely managed and we confirmed audits were in place within the consultation and treatment rooms. Where concerns were identified, an action plan was put in place.

Sharps receptacles were in place in the treatment rooms and containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury.

The practice had a legionella assessments and audits in place. The practice had suitable and sufficient risk assessments required to identify and assess the risk of exposure to legionella bacteria from work activities. Water systems on the premises were checked to ensure continued safety.

**Equipment**

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. We confirmed equipment was checked regularly to ensure it was in working condition. A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We saw equipment was calibrated and maintained regularly and we saw equipment maintenance logs and other records confirmed this.

**Staffing and recruitment**

The practice had a recruitment policy in place. The policy stated all staff should have references in place prior to employment being offered. We looked at a sample of personnel files for nurses, health care assistants and reception staff. Most of the staff had worked for the provider for several years. We looked at the most recently recruited staff and saw that most of the pre-employment checks were in place, these included a full work history, evidence of identity, references and where required a DBS

check. However two member of staff recruited did not have references in place. We were told this was because they were already known by one of the GPs. The practice did not follow the practice's own recruitment procedure.

We saw that the practice manager monitored the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice.

We saw safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness.

**Monitoring safety and responding to risk**

The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner.

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents. There were arrangements in place to protect patients and staff from harm in the event of a fire. This included staff designated as leads in fire safety and carrying out appropriate fire equipment checks. Staff told us that fire drills took place regularly.

The practice was positively managing risk for patients. Patients with a significant change in their condition or new diagnosis were discussed at GP and multi-disciplinary team (MDT) meetings, which allowed clinicians to monitor treatment and adjust support according to risk. We saw information regarding palliative care patients was made available to out of hours providers so they would be aware of changing risks. We were also told that a dedicated line was made available to frail patients who needed more immediate support.

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

We saw evidence that all staff had received training in Basic Life Support. This was updated on a regular basis. There was an automatic external defibrillator (AED) in the practice. All staff knew where this was kept and how it should be used. Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. We saw there were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aims to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 95% of the QOF framework points in year 2013-14, which showed their commitment to providing good quality care.

There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for patients on their electronic records. This coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. This helps to improve patient care by ensuring clinicians based their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with the coding and its benefits when assessing patients' conditions.

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For instance, they applied the NICE quality standards and best practice guidance in their management of conditions such as asthma and diabetes. We saw minutes of GP clinical meetings where new guidelines were disseminated and the implications for patients and the practice's performance were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers, for patients with long term conditions. These included asthma and chronic heart disease and were used to arrange annual, or as required, health reviews.

The practice had developed services and worked with local schemes, such as Hepatitis screening and the Bradford Beating Diabetes campaign to monitor and improve the health outcomes of these patients The practice had identified that there was a high prevalence of diabetics in their patient population. To enable them to manage this risk to patients effectively they held regular diabetic clinics and were involved in the Bradford Beating Diabetes campaign. Information about diabetes was provided in languages relevant to the patient population. A patient told us they had been provided with information about the risks of diabetes and healthy lifestyle and diet. Staff involved with the clinics told us they had received training in diabetes disease management.

We saw patients were appropriately referred to secondary (hospital) and community care services. The GPs and nursing staff we spoke with clearly outlined the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring each patient was given support to achieve the best health outcome for them. Feedback from patients confirmed they were referred to other services or hospital when required

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

The practice completed full health assessments on new patients and followed up any identified health needs. Clinics for patients with health needs such as, coronary heart disease, diabetes, asthma and COPD were held and systems were in place to identify patients who met the criteria to attend.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example in dementia support, patients with a definite diagnosis had regular appointments to meet their needs. The patients who had been identified to be at risk of developing dementia were provided with the opportunity for an annual dementia screening.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included prescribing audits such as use of anti-psychotics in dementia and a dyspepsia (gastro-oesophageal reflux disease) audit. The practice was making use of clinical audit tools to reflect on the outcomes being achieved and areas where they could be improved.

Staff regularly checked that all routine health re-assessments were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP or the

pharmacist. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the clinical staff had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patients' needs.

The GPs from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

**Effective staffing**

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. We were able to review staff training records and we saw this covered a wide range of topics such as health and safety, basic life support, and infection control. The practice ensured all staff could readily update both mandatory and non-mandatory training and this was provided through e-learning and face to face training. Newly employed staff were supported in the first few weeks of working in the practice and completed an induction programme.

All the patients we spoke with were complimentary about the staff. We observed that staff were competent and knowledgeable about the roles they undertook. The practice was organised so there were enough staff to meet the fluctuating needs of patients.

We saw evidence of regular training for staff but there was no overall account of training completed or training that required an update. We discussed this with the practice manager who agreed that they would put a training plan in place to ensure that important training or updates were not missed.

All GPs were up to date with their continuing professional development requirements. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The advanced nurse practioner we spoke with confirmed their professional development was up to date.

We saw some appraisals were in place and staff told us it was an opportunity to discuss their performance and any training concerns or issues they had. All the staff we spoke with were unanimous they were well supported in their role and confident in raising any issues with the practice manager or the GPs.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff. We saw where performance concerns had been identified appropriate action had been taken to manage this.

**Working with colleagues and other services**

There were regular GP clinical team meetings and evidence of positive working relationships with multidisciplinary teams. National Institute of Health and Care Excellence (NICE) guidance was referenced and used consistently. We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services, community learning disability teams and community mental health teams to support patients.

The practice worked with other service providers to meet patients' needs. Treatment information from hospitals and Out of Hours (OOH) services was received and reviewed as per the practice policy.

The staff attended multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

The practice was part of a 'City Health Federation'. One of eighteen practices that had joined together to mutually support one another and to share resources such as clinics and professional expertise.

**Information sharing**

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their

# Are services effective?

## (for example, treatment is effective)

patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients.

There was a practice website with information for patients including signposting services available and the latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area.

**Consent to care and treatment**

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties with respect to these. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment. There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone was unable to give consent, including escalating this for further advice to a senior member of staff where necessary. We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and would seek appropriate approval for treatments.

We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments checked whether children and young people had the maturity to make decisions about their treatment.

**Health promotion and prevention**

The practice raised awareness of health promotion during consultations, via information boards and leaflets in practice waiting areas and on their web site were links to further advice. There were screening programmes in place to ensure patients were supported with their health needs in a timely and safe way. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We observed that reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. The practice switchboard was located in an area away from the reception so calls could not be overheard. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality. In the GP Patient Survey 2014 NHS England the practice rated highly in response to ' reception maintaining confidentiality'.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard. The staff were aware of the practice policy on chaperoning and were familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations. We saw that a private room was made available for patients if additional support was required.

Leaflets were available in the waiting room which signposted patients to areas for support such as; bereavement counselling, mental health support and also support with conditions such as cancer. Staff also confirmed that GPs always contacted patients after a bereavement in their family to offer condolences and further support.

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

Patients were supported to express their views and were involved in making decisions about their care and treatment. Patients we spoke with said they had been involved in decisions about their care and treatment, and staff explained things clearly to them. Patients confirmed they understood their treatment and options were discussed during their consultation.

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

In the GP Patient Survey 2014 NHS England 88% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. We also saw that 83% of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care.

All the patients who responded to CQC comment cards, and those we spoke with during our inspection, were very positive about their care. They all confirmed that during consultations and treatment staff were caring and respected their dignity.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff had the overall competence to assess each patient and were familiar with individual's needs and the impact of their socio-economic environment.

There was a register of the housebound and patients who required palliative care. The practice also provided a dedicated telephone line to patients to respond to their changing needs.

Patients with immediate, or life-limiting conditions, were discussed at the weekly clinical meeting to ensure all practitioners involved in their care delivery were up-to-date and knew of any changes to their care needs.

There was a register for patients with learning difficulties and they were offered annual health assessments.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. The practice ensured that patients had appointments for all their conditions together to minimise additional visits to the surgery.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for patients over the age of 75 and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review.

We saw there was a process in place for 'Choose and Book' referrals to other services. We saw referrals to other services were done promptly after their consultation with the GP.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population. We saw the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

**Tackling inequity and promoting equality**

There was good access to the building, automatic doors at the entrance, accessible toilets and all treatment rooms were on the ground floor. There was a large car park with disabled parking bays available. There was a comfortable waiting area large enough to accommodate patients who used wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Staff told us translation services were available via 'language line' during consultations for patients who did not have English as a first language. We also noted that staff had been appointed with different language skills in reception to support people with making appointments and translating information where required. The screens in the waiting area and leaflets available also had important information translated into different languages.

**Access to the service**

Of the patients who participated in the GP Patient Survey 2014 NHS England 97% of patients reported a good overall experience of making an appointment at the practice.

The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met. The practice had surveyed patients to look and at the best way to improve access to the surgery. They had introduced extended opening hours, employed additional staff and added a pharmacist to the team in order to deal with minor ailments and to encourage patients to self-manage their health.

Patients we spoke with said they found it easy to make a routine appointment with a named GP usually within five days and that there was continuity of care, with urgent appointments available the same day. There was an 'on call' GP who was scheduled to take all emergency appointments and home visits to patients where necessary.

Patients could make appointments at the practice, by telephone, or the internet. They were further supported with text messaging to remind them of their appointments. On line services were promoted to make appointments or order prescriptions and social media was being developed to communicate with patients i.e. twitter.

# Are services responsive to people's needs?

## (for example, to feedback?)

Patients were offered extended appointments for those who needed support with communication or had multiple health needs.

Local radio was used to promote the practice with GPs from the practice broadcasting on the local radio station the services they provide and to promote health care.

Opening times and closures were stated on the practice website and in the practice leaflet with an explanation of what services were available. Services had been developed to support patients cultural and religious needs, extending open hours whilst patients were fasting.

The practice had introduced the role of patient engagement lead who provided a link for patients and ran health information sessions and links to support networks for patients e.g. age concern and the Alzheimer's society. They also informed patients of what the practice can provide and raised awareness of patients' rights.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There is a designated person, the practice manager, who handles all complaints in the practice.

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception and displayed in the reception area. There was a suggestion box in the waiting area for patients use. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Staff we spoke with told us there was an open door policy for staff and patients so concerns or complaints could be responded to in a timely manner. The practice manager kept a log of complaints about the practice. We looked at the complaints over the past 12 months. We saw these complaints were investigated and concluded in accordance with the practice's guidelines and procedures.

The practice had also undertaken their own survey with patients and from those responses had put actions in place. For instance due to patient responses they had put a new phone line in place with a local number and additional phone lines to meet with demand. They had also appointed an additional female clinician to meet the needs of female patients.

# 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**

Staff we spoke with shared joint values about the practice and knew what their responsibilities were in relation to these. All staff spoke positively about the management and they felt valued as employees at the practice. All staff told us that central to their values were the needs of the patient.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at three of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There were clear management structures in place. Allocation of responsibilities, such as lead roles in clinical governance, safeguarding, infection control and the management of complaints were in place. All staff we spoke with said they knew their own roles and responsibilities within the practice.

We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at clinical meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example in relation to the management of medicines and vaccines.

The practice sought feedback from patients and staff to help improve the service. The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and the main issues were access to appointments and availability of GPs. We saw actions had been taken to extend opening hours in the morning and evening to accommodate patients' needs. More appointments with the GP were made available. Patients were now being encouraged to use on line facilities to make and cancel appointments and to use their mobile phone (with their written consent)to receive results.

The staff felt they could raise any concerns at any time with either the GP or practice manager, as they were considered to be approachable and responsive. The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

**Leadership, openness and transparency**

All clinicians and reception staff told us there was an open culture within the practice and they were happy to raise issues at meetings. Systems were in place to encourage staff to raise concerns and a no blame culture was evident at the practice.

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

The practice had gathered feedback from staff, through staff training days and generally through staff appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff confirmed they felt part of the decision making in the practice and their contributions mattered to the team.

The practice surveyed the patient population with a qualitative questionnaire and took action from these results. For instance they had taken action to increase the access to appointments overall. We also saw that a suggestion box was in place and any comments received were acted upon.

The practice did not have an active patient participation group (PPG). However the practice had put into place a patient involvement lead to promote the practice and link with patients.

**Management lead through learning and improvement**

We looked at three staff files and saw that regular appraisals had taken place. Staff told us that the practice was very supportive of training and that they were given protected time to undertake further training.