

Dr Syed Hamdani

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 Hamdani's practice on 17 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Patients said they were treated with compassion, dignity and respect. They were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and there was continuity of care. Urgent and walk in appointments were available on the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Risks to patients were assessed and well managed, but were not collated in a risk log.
- The practice was equipped to treat patients and meet their needs but the building required updating to improve access.

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

Importantly the provider should:

Summary of findings

- Review arrangements for audit and risk management to include thematic review.

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?

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.

Good



Are services effective?

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 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 of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

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). Patients said they found it easy to make an appointment and there was continuity of care. Urgent and walk in appointments were available on the same day. The practice had identified the premises required improving and had a business improvement plan in place to improve access for all patients. The practice was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints with staff and other relevant stakeholders.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. The practice had a business improvement plan. Staff were clear about their roles and responsibilities. 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 meetings. There were systems in place to monitor and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Membership of the patient participation group (PPG) had declined and the practice was actively trying to recruit new 'virtual' members. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice 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. For example, Heart failure and Atrial fibrillation. The practice offered proactive, personalised care to meet the needs of the older people in its population. They had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people. They offered home visits and rapid access to appointments for those with enhanced needs via a dedicated telephone number. The practice offered home visits for flu vaccinations for those who could not attend the surgery.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. 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 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. The practice referred patients with heart conditions to the Bradford Healthy Hearts initiative.

Good



Families, children and young people

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. Those who were at risk, for example, children and young people who had a high number of A&E attendances were followed up by practice staff. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way. Appointments were available outside of school hours. We saw good examples of joint working with midwives, health visitors and school nurses and the local health on the streets (HOTS) initiative.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

been identified. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were given information and referred to local support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety four percent of 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. Staff carried out advance care planning for patients with dementia and offered dementia screening and had signed up to the Dementia Identification Scheme.

The practice signposted patients who experienced poor mental health to various support groups and voluntary organisations. Staff had a system in place to follow up patients who had attended accident and emergency (A&E) with mental health conditions. Clinical staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We received 26 completed CQC comment cards and spoke to five patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

Patients were very satisfied with the service they received from the practice and this was aligned to the written feedback on the comment cards. Patients told us they were treated by staff with compassion, dignity and respect. Their health issues were discussed with them and they were involved in decision making about the care and treatment they received. They told us they felt listened too and were never rushed and all staff were very caring.

Several comments complimented the availability of appointments that could be booked on the day. One comment card reported it was difficult to get through to the practice by telephone to make an appointment.

Patients told us the practice was always clean and tidy but reported the premises needed updating to

accommodate the needs of all patients. We observed that patients had to go through three single doors in an L shaped corridor to access the reception window and then through another door to get to the waiting room.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 and a survey of 44 patients undertaken by the practice manager. The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. The practice was well above the CCG average for its satisfaction scores on consultations with nurses with 85% of practice respondents saying the nurse was good at listening to them and 86% saying the nurse gave them enough time. The GP scores were slightly lower than the CCG average with 83% of practice respondents saying the GP was good at listening to them and 83% saying the GP gave them enough time.

Areas for improvement

Action the service SHOULD take to improve

- Review arrangements for audit and risk management to include thematic review.

Dr Syed Hamdani

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor.

Background to Dr Syed Hamdani

Dr Hamdani, or Eccleshill Village Surgery as it is known locally, is located in the village of Eccleshill on the outskirts of Bradford. The practice provides personal medical care services for approximately 3,250 patients under the terms of the locally agreed NHS Primary Medical Services contract. The practice catchment area, which includes Eccleshill, Five Lane Ends, Idle and some areas of Greengates, is classed as within the group of the third most deprived areas in England. The age profile of the practice population is broadly similar to other GP practices in the Bradford District Clinical Commissioning Group (CCG) area.

The practice is owned by the full time male GP with one part-time male GP who works one regular clinical session each week. They are supported by one advanced nurse practitioner, one locum practice nurse/nurse prescriber, two healthcare assistants, five administrative staff and one practice manager.

The practice is open weekdays from 8am to 6.30pm with extended opening every Monday morning from 6.30am. The practice is closed one Thursday afternoon per month for planned training sessions. The practice is also open on Saturday mornings during the winter months from 9am to 11am. Minor surgery, diabetes, asthma, family planning,

antenatal and mother & baby clinics are run each week. Out of hours care is provided by Local Care Direct and is accessed via the surgery telephone number or calling the NHS 111 service.

Dr Hamdani's Surgery 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 Eccleshill Village Surgery, 14 Institute Road, Eccleshill, Bradford, BD2 2HX.

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.

Please note 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

Before visiting, we reviewed information we hold about the practice and asked Bradford District Clinical Commissioning Group (CCG) and NHS England to share what they knew. We carried out an announced visit on 17 February 2015. During our visits we spoke with one GP, the practice manager, two nursing staff, one healthcare

Detailed findings

assistant and two members of the administrative team. We also spoke with five patients who used the service and reviewed 26 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)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of practice meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. 'Significant events' was a standing item on the monthly practice meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they told us they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example we were told how the procedure for sharing written communication with patients or their significant others had been reviewed and updated following an incident where a relative was given another patient's information. We reviewed the minutes of the practice meeting where the incident had been discussed and were shown an email cascaded to all staff to inform them of the change in procedure. Staff had signed a cover sheet to acknowledge the change which was stored in the incident folder. We saw notes that the patient's family had been contacted and informed of the incident. The notes recorded an apology had been given and the relative informed of actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff via email and also a copy

printed off and stored in the alerts folder. Staff signed the alert cover sheet in the folder to record they had received it. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Staff told us alerts were discussed at practice meetings and subsequent actions recorded.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The full time GP was the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example those patients who were being supported by the alcohol adviser who held a clinic at the practice once a week. GPs were appropriately using the required codes on their electronic patient record system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Practice staff attended children protection case conferences and serious case reviews where appropriate and reports were sent to the practice if staff were unable to attend. We were told about a referral made to social services by practice staff for a vulnerable person who required further support.

Are services safe?

The practice held monthly multidisciplinary meetings which the health visitor, community paediatrician, community matron, palliative care team, pharmacist, physiotherapy and occupational therapists attended. Other health and social care staff attendance could be requested if needed. The practice had a procedure to follow up children who persistently failed to attend appointments at the practice which was actioned by the nursing staff.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). Two administration staff were trained as chaperones and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. 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. The practice staff followed the policy.

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.

The nursing staff were qualified as independent prescribers. They received regular supervision and support in their roles as well as updates in the specific clinical areas of expertise they prescribed.

The practice was supported by the CCG Pharmacist Lead who reviewed prescribing data. There was a Community Pharmacist who could visit patients at home to review their medicine if necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place for the whole surgery but not for individual treatment areas. Cleaning schedules and records were kept for the whole surgery but they were not available in each individual treatment room. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out audits for each of the last three years and any improvements identified for action were completed on time. Minutes of practice meetings showed the findings of the audits were discussed. A recent audit had identified the carpet in the waiting room should be removed to assist adequate cleaning of the area. We were told this was in progress as part of the building improvement plan.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Reception staff told us how they would deal with specimens from patients. There was also a protocol for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

Are services safe?

and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The practice had recently purchased a new defibrillator and we noted there was not a maintenance log for this. We reported this to the practice manager on the day of our inspection.

Staffing and recruitment

Records we looked at contained evidence appropriate recruitment checks had been undertaken 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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The appointments systems in place allowed a responsive approach to risk management. For example, where there were no appointments available for people on the same day, the GP would telephone the patient to assess their symptoms over the telephone and arrange appropriate care. We were told those patients who were at high risk of admission to hospital were given a dedicated telephone number that was answered as a priority by reception staff.

Individual areas of risk were identified and logged separately and discussed at practice meetings. We saw risks were discussed at practice meetings and within team meetings but not collectively recorded within a risk a log. For example, we saw minutes of a practice meeting where challenging behaviour during home visits was discussed. It was noted staff should report any instances of challenging behaviour on the practice system.

We saw staff were able to identify and respond to changing risks to patients including over or under prescribing. For example practice staff showed us how they monitored repeat prescribing for people receiving medication for mental ill-health to ensure they were not receiving too much or too little of their medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. Records confirmed emergency equipment was checked regularly except the new defibrillator. Staff told us they would add the defibrillator to the equipment check schedule.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff told us how the emergency medicines were organised so they could be accessed quickly in an emergency.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Are services safe?

the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment this included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised weekly fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GP and nurses they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the advanced nurse practitioner supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We were told us this supported all staff to continually review and discuss new best practice guidelines. For example the management of blood clots in the legs. Our review of the practice meeting minutes confirmed best practice guidance was discussed and actions agreed.

The GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. We were shown a completed review of case notes for patients who were taking blood thinning medication which showed all were receiving appropriate treatment and regular reviews. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used, to review patients those patients in the community who were at high risk of hospital admission. They were discussed at joint integrated care meetings with another practice in the area and attended by community staff, community support officer, carers support officer, community nurses and a GP from each practice. Patients were reviewed by the team according to their

individual need and referral to relevant service made. For example a patient experiencing mobility problems would be referred to the community physiotherapy team and social/home care if they lived alone.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The GP we spoke with used national standards for the referral of conditions which included elective muscular- skeletal conditions and patients with suspected cancers referred and seen within two weeks. The practice also contributed to the Elective Care Incentive Scheme facilitated by Bradford and District CCG to use clinical pathways as a decision aid. These helped to improve patient outcomes, experiences and promote best practice within the local area. We saw minutes from meetings where regular reviews of elective and urgent referrals were made. The improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP showed the culture in the practice was patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to monitor the practice progress which staff told us was shared with them informally on a weekly basis.

The practice showed us six clinical audits that had been undertaken in the last two years which had been mainly completed in partnership with the pharmacist or external organisations arranged through the CCG. The GP and nurses told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Two of the practice audits were

Are services effective?

(for example, treatment is effective)

completed and they were able to demonstrate the changes resulting since the initial audit. We were shown an audit of patients taking a medicine for osteoporosis, a condition that affects the bones, causing them to become weak and fragile and more likely to break. The audit highlighted not all patients were taking a vitamin D and calcium supplement. Following the audit the patients were reviewed and vitamin D and calcium prescribed. We asked to see an annual audit cycle and were told staff completed individual or partnership audits that were not built into an annual cycle.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 89% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. We were told how clinical staff would access external supervision and support through their clinical networks. For example the advanced nurse practitioner told us they received supervision from a hospital consultant for gynaecological conditions. Staff spoke positively about the culture in the practice around quality improvement. We noted all staff were actively encouraged to get involved and contribute via practice meetings.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. The GP told us after receiving an alert, they would review the use of the medicine in question. If they continued to prescribe it they would outline the reason why they decided this was necessary.

The practice was working towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as

multidisciplinary meetings to discuss the care and support needs of patients and their families. End of life care was also a standing item on the practice meeting agenda. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register to include all patients who required end of life care.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. We noted the GP had additional qualifications in acute medicine. The advanced nurse practitioner held a diploma in gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation had been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals and identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses. For example a member of the nursing team was being supported to achieve a diploma in diabetes.

Nursing staff performed defined duties and were able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology and child health clinics. Those with extended roles would see patients with long-term conditions such as asthma, COPD, and coronary heart disease and they were able to demonstrate they had appropriate training to fulfil these roles.

Are services effective?

(for example, treatment is effective)

The practice manager told us where poor performance had been identified appropriate action would be taken following the practice's policy. They told us they did not have any recent examples of when the policy had been used.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The practice told us about a recent incident where communication from the hospital was not actioned correctly. We saw the procedure had been reviewed, staff informed of the change in practice and we were told it was now working well.

The practice was commissioned for the avoiding unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held separate monthly palliative care and community integrated care team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses, community staff and others. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We were told a patient had been given access to specialist sporting facilities following a referral to the physiotherapist.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP 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, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use.

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence checks had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. 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. Clinical staff told us they had attended the relevant training sessions. Non-clinical staff told us they had received updates during a practice training session for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but had not completed any formal training.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice had reviewed 92% of dementia care plans in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All

Are services effective?

(for example, treatment is effective)

clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes. A signed consent form with a record of the relevant risks, benefits and complications of the procedure was scanned onto the patient record system for more complex procedures.

The practice staff told us that they had not needed to use restraint in the last three years. They were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. Chlamydia screening packs were available in the reception area for patients to perform at home. The sample would then be sent for analysis using a freepost service. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in

offering additional help. For example, the practice kept a register of all patients with a learning disability and all offered an annual physical health check. Practice records showed 50% had received a check up in the last 12 months. The practice had also identified the smoking status of 97% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 25%, which was similar compared to neighbouring practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. There was also a named nurse responsible for following up patients who did not attend screening. Staff told us all patients who did not attend any screening programme were followed up by practice staff.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice also offered 24 hour blood pressure recordings, minor surgery excluding cutting, spirometry and resting echo cardiograms.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 and a survey of 44 patients undertaken by the practice manager. The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. The practice was well above the CCG average for its satisfaction scores on consultations with nurses with 85% of practice respondents saying the nurse was good at listening to them and 86% saying the nurse gave them enough time. The GP scores were slightly lower than the CCG average with 83% of practice respondents saying the GP was good at listening to them and 83% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards and they all were positive about their experiences. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One card contained a less positive comment reporting it was difficult to get through to the practice by telephone. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients treatments so confidential information was kept private. The practice switchboard was located away from the reception window and was shielded by glass partitions which helped keep patient information private. The waiting room was in a separate room to the reception area. The practice scored well above the CCG average on the national GP patient survey for privacy in the reception area.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Reception staff told us they had not needed to refer to it recently.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 77% of practice respondents said the GP involved them in care decisions which was slightly above the CCG average of 76.5%. The results from the practice's own satisfaction survey showed 87% of patients said they were sufficiently involved in making decisions about their care and 72% reported the GP or nurse was good about explaining conditions and treatment to the patient.

Patients we spoke with on the day of our inspection told us 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 comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, they highlighted staff responded compassionately when they needed help and provided support when required. We were told by one patient how

Are services caring?

they had been supported emotionally by practice staff to come to terms with their illness. They were referred onto counselling to develop coping skills to manage their condition.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. One notice board was dedicated to families and children and the groups supporting child development and parenting. Other notice boards included information from the patient survey, self care topic advice and details of the local carers group. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them and how to register with a local carer's group.

Staff told us if families had suffered a bereavement, they would be offered details of bereavement services and

could also book appointments with either the nursing staff or GP. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice was one of six GP surgeries in the area contributed to the Health On The Street scheme which offers a range of support packages to patients in non-traditional settings such as community centres, which patients found more convenient. We were told the scheme was a great success and one support package was for those recently bereaved who wanted to improve their cookery skills. We were shown the weekly schedule of activities available to patients which included walking groups, swimming group, younger peoples drop in centre, weight management, confidence building courses and an ante/post natal drop in group. One patient told us that they had been referred to some of the groups which they found particularly useful and gave them confidence.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and where service improvements needed to be prioritised. We saw minutes of meetings where this had been discussed and also a business improvement plan to update the premises.

The practice had also previously implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. We were told following feedback from patients the practice released more pre-bookable appointments in advance for patients to book routine appointments. The practice had a Patient Participation Group and membership had declined more recently. We were told the practice was actively recruiting new members and saw posters in the practice and notices on the practice website encouraging patients to join a 'virtual' PPG.

We were shown completed NHS Friends and Families cards from December 2014 all which rated the practice good or above.

A benefits advisor held a surgery in the practice once week to offer advice about benefits, tax credits, as well as council tax and social housing. Staff told us patients spoke very highly about this service and the appointments booked up quickly.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We were told how carer's were actively reminded to book their annual health checks when they visited the practice.

The practice had access to online and telephone translation services and staff who spoke Urdu and Punjabi languages.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the training in the last 12 months and it was regularly discussed.

The practice premises comprised of a two storey detached building with a flat roof that contained a reception area, waiting room, five treatment rooms and patient toilet facilities on the ground level with offices and a staff room in the basement. It was accessed via ground level and all of the services for patients were on this floor. The manual entrance door to the practice was wide enough to accommodate wheelchairs and prams and patients had to go through two further internal doors in an L shaped corridor before they reached the reception window. Reception staff told us they would assist patients with wheelchairs and prams by holding the doors open for them. The practice waiting area was located in another room opposite the reception window and was accessed via another door. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams but did not allow for easy access to the treatment and consultation rooms as another door had to be opened to gain access to the area. Patient information boards adorned the walls in the waiting room with specific notice boards relating to family information services and events, self-care, live well, carers and the patient survey results. The individual chairs had wipe clean covering.

The reception area was to the front of the practice with external and internal glass windows and contained fixed height workstations with a small kitchen sink and tea and coffee making facilities at the far end. The basement contained a meeting room and offices for practice staff. The patient toilet facilities were large enough to accommodate those needing assistance. We observed they were not suitably equipped to promote patient independence as there were no hand rails. We were told there were no baby changing facilities in the practice. Practice staff told us the flat roof had leaked in the past and been repaired.

Patients told us the premises were in need of an update particularly the reception area and the waiting room as they looked dated and did not allow for good access. We were shown the business improvement plan to develop the practice reception area and waiting room and improve patient toilet facilities. We were told the business improvement plan had been submitted to the CCG for funding.

Are services responsive to people's needs?

(for example, to feedback?)

The practice actively supported patients who had been on long-term sick leave to return to work by referring patients to the activities facilitated by Health on the Street Scheme. The practice website referred to fit notes and where to find further information about them.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the waiting room area informing patients this service was available. Reception staff at the practice spoke Urdu and Punjabi and the GP spoke Urdu.

Access to the service

GP Appointments were available from 8am to 10.30am and 3.30pm to 6pm on weekdays with the option of appointments from 6.30am on Monday mornings. Nurse appointments were available from 8.30am to 6pm during the week. The practice was open from 9am to 11am on Saturday mornings during the winter months. The advanced nurse practitioner offered 'walk-in' appointments for patients with minor trauma. For example slips, trips and falls. We were told about a patient who had slipped on the ice and came into the surgery and their injury was treated in the practice by the advanced nurse practitioner. This prevented the need to attend the accident and emergency department for treatment.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patients told us that they were satisfied with the appointments system and this was echoed in the CQC comment cards. They confirmed they could see a doctor on the same day if they needed to. For example, one patient we spoke with told us how they needed an urgent appointment and they called the practice that morning and were seen by the GP half an hour later.

The practice's extended opening hours on from 6.30am on Monday morning and 9am to 11am on Saturday mornings was particularly useful to patients with work commitments. We were shown feedback from a patient who worked away during the week and came home at weekends. He provided feedback to the practice how convenient it was to be able to see a doctor and have tests performed on a Saturday. The national GP patient survey reported 98% of respondents stated the last appointment they had at the practice was convenient.

Students who moved away from the area during term time remained on the practice list and this was actively encouraged. Repeat prescriptions could be ordered via the practice website and the practice told us they were introducing on line appointment booking in April 2015. Patients could register to receive text message reminders of their appointment time and receive blood test results by text message for those patients who had requested it.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system including information on the website and leaflets in the practice. We noted the complaints leaflet and information on the practice website referred to the legacy primary care trust which had been replaced by the CCG. We reported this to the practice manager at the time of our inspection. Reception staff told us if a patient wanted to give feedback to the practice the practice manager would be informed and would then arrange to speak to the patient. Feedback was recorded on a comment form and fed back at practice meetings. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint within the last year about the practice.

We looked at four complaints received in the last 12 months and found they were dealt with in a timely way and handled satisfactorily and where appropriate involved other agencies to respond to the complaint. The complaint response addressed the areas of concern, detailed the

Are services responsive to people's needs? (for example, to feedback?)

investigation that took place and the findings. An apology was given where appropriate. We noted and fed back to the practice manager response letters should include details of the health service ombudsman for the complainant to pursue further if they felt necessary. We were shown details of a complaint where a patient had arrived for two appointments and one was not booked on the system. We were shown an email to staff to remind them the importance of booking all the requested appointments for the patient and it was noted the patient was booked into the relevant appointment and given a verbal apology.

The practice reviewed complaints monthly at the practice meeting to enable to staff to learn from complaints and contribute to determining any improvement action might be required. Clinical staff told us clinical complaints were reviewed within the clinical group but we were not shown any minutes of those meetings.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a statement of purpose and staff spoke enthusiastically about working at the practice and they told us they felt valued and supported. We were told the practice had a business improvement plan that included improvements to the building and staff told us their role was to provide the best care to patients. We asked if the practice had developed an overall vision or practice values that staff had taken time out to contribute to and staff told us this happened informally at the practice meetings where all staff contributed.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in files within the practice. We looked at 10 of these policies and procedures and most all staff had completed a cover sheet to confirm they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually. We noted and fed back the recruitment policy referred to Criminal Record Bureau checks that had been replaced by the Disclosure and Barring Service checks and the complaints policy referred to the Primary Care Trust. All other policies were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the full time GP was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We were not shown an on-going programme of clinical audits; although we were shown the individual evidence they were taking place.

The practice had arrangements for identifying, recording and managing risks but did not collate this information on a risk log. The individual risks were regularly discussed at team meetings and incident forms updated in a timely way.

The practice held monthly practice meetings where governance issues were discussed. We looked at minutes from the last three meetings and found performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes, team meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and the induction policy which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, NHS Friends and Family test, comment cards and complaints received. We looked at the results of the annual patient survey and six percent of patients reported telephone access was poor. We saw as a result of this the practice was exploring an additional telephone line for the practice.

The practice had an active patient participation group (PPG) which had steadily decreased in size. We saw evidence in the practice and on the website they were actively trying to recruit more virtual members.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and available within the practice.

Are services well-led?

Good 

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

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw regular appraisals took place which included a personal development plan. We were told the practice was very supportive of training and they had regular staff training days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to help ensure the practice improved outcomes for patients. For example where communication from the hospital was not actioned correctly. We saw the procedure had been reviewed, staff informed of the change in practice and we were told it was now working well.