Dr Usman Akbar

Quality Report

Bluebell Building, Barkerend Health Centre
Bradford BD3 8QH
Tel: 01274 663553
Website:

Date of inspection visit: 18 November 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection visit on 18 November 2014 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence that the practice was safe, effective, caring, responsive and well led.

Our key findings were as follows:

- The practice provided good, safe, responsive and effective care for all population groups in the area it serves.
- All areas of the practice were visibly clean.
- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep patients and staff safe.
- 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 was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- 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 these included:

- The practice has 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 is working with the local hospital to screen patients for Hepatitis B & C.
- The practice is opening on Saturday mornings during the winter months to help reduce hospital pressures.

Summary of findings

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 people safe.

The building required improvement; this was the responsibility of the landlord and we saw the practice had been proactively working with the landlord for improvements to be made.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health.

Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. Staff worked with multidisciplinary teams and proactively identified those patients at risk of developing long term conditions which were specific to their patient population. They had developed services and worked with local schemes, such as the Bradford Beating Diabetes campaign to monitor and improve the health of these patients.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than other practices in the area for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS England Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Summary of findings

Patients reported good access to the practice and a named GP and 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. There was an accessible complaints system with evidence demonstrating the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). 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 patients. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older patients, including offering 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 population group of patients with long term conditions. Emergency processes were in place to refer patients, in this group, who had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews 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.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. Systems were in place for identifying and following-up children living in disadvantaged circumstances and/or those who were at risk. For example, the practice followed up those 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 and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients including those recently retired. The needs of the working age population and those recently retired, had been

Summary of findings

identified and 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 online services as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities; these appointments were longer than usual. All of these patients had received follow-up care where needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). One hundred per cent of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 20 CQC patient comments cards where we found very positive comments about the practice and the staff. Comments included how helpful the reception staff were as they tried to ensure appointments are at the earliest convenience for patients.

Patients told us the staff were very helpful, respectful and supportive of their needs. They felt all staff communicate well with them well; they were involved and felt supported in decisions about their care. They felt the clinical staff responded to their treatment needs and they were given a caring service. However three of the completed CQC comment cards stated they had difficulty getting through on the phone line to the practice in a morning. However other comments included the benefits of having open surgeries every Monday & Friday and that no-one was ever turned away.

Outstanding practice

- The practice is working with the local hospital to screen patients for Hepatitis B & C.
- The practice is opening on Saturday mornings during the winter months to help reduce hospital pressures.
- The practice has 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).

Dr Usman Akbar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP and a CQC inspector.

Background to Dr Usman Akbar

Dr Usman Akbar's Pratice is situated in a single storey, purpose built building situated in the centre of a residential area in the inner city area of Bradford. It was built in the late 1960's and provides a range of consulting and treatment rooms with supporting administrative areas. The practice shares the building with three other practices.

The practice provides Personal Medical Services (PMS) for 2264 patients under a contract with NHS England, Bradford. Our information shows that the practice population has significantly higher than national average 0-39 year old age group and lower than average 50 plus age group. The practice is situated within the most deprived area of Bradford. The practice is a single handed GP with a salaried female GP in attendance each Wednesday morning. The GPs are supported by a practice pharmacist one day a week, to ensure safe prescribing of medicines. They are also supported by an advanced nurse practitioner and a team of practice nurses who are employed by BDCT Bradford District Care Trust. This team have provided support to Dr Akbar's practice on a contractual basis for over eight years; to meet the needs of the practice population. In addition there is an experienced team of administrative and reception staff support the practice. This includes a practice manager, five receptionists/ administrators.

The practice has open access surgeries every Monday and Friday. Telephone consultations can be pre-booked each Tuesday and Thursday. The surgery hours are 8 am to 6.30pm, Monday, Tuesday, Thursday and Friday and Wednesday 8am to 1pm. The practice is also offering Saturday morning appointments from October 2014 until March 2015. This is part of the local Clinical Commissioning Group (CCG) 'Winter Pressures' initiative to help reduce the number of patients who access the out of hours (OOH) service over the winter months. Repeat prescriptions can be ordered in a variety of ways, on-line, in person, by post and at dedicated times via the telephone.

Patients can access out of hours services via Local Care Direct on 111. They provide the out of hours service on behalf of NHS Bradford City Clinical Commissioning Group (CCG).

The practice has 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 has quarterly newsletters for patients, where timely information about the practice and its services are highlighted. It also included the current wait for routine appointments with the GP.

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 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the NHS Bradford City CCG, to share what they knew.

We carried out an announced visit on 18 November 2014. During our visit we spoke with a range of staff including one GP, one practice nurse, a pharmacist, a health care assistant (HCA), two receptionists and the practice manager. We also spoke with three patients who used the practice including a member of the practice's Patient Participation Group (PPG).

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 20 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Information from the General Practice Outcome Standards (GPOS), Quality Outcomes Framework (QOF) and Bradford City Clinical Commissioning Group (CCG) information showed the practice rated as an achieving practice. We also found they had been accredited by the local CCG data quality group for being paper less. (Mainly electronic document systems were used within the practice).

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources including the QOF, patient survey results, patient feedback forms, the Patient Participation Group (PPG), clinical audit, appraisals, professional development planning, education and training. We reviewed safety records and incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could demonstrate a safe track record over the long term.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the regular monthly practice meetings.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. The practice manager provided a summary of the three significant events which occurred in 2014. We also reviewed the significant events records at the practice. Significant events and complaints were 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. For example, following an incident relating to a patient's fast track referral, systems were changed within the practice. This system was to be re-audited again.

We saw records of incidents, investigation and actions taken. We saw where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken. We found from records that action had been taken, following incidents, to safeguard patient's health and welfare where necessary. We saw where incidents had involved other organisations these had been communicated to the relevant department and action had been taken to minimise the risk of errors reoccurring.

Reliable safety systems and processes including safeguarding

There were comprehensive policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed on to the relevant authorities by staff as quickly as possible. Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. The lead GP (for safeguarding vulnerable adults and children) was trained to Level 3 and they informed us they had participated in local safeguarding meetings for their patients, when required. We saw that alerts were placed on patients' electronic records to inform staff of any safeguarding issues for individual patients who attended for consultation.

We saw an up to date chaperone policy and protocol. We were told the administration staff had received instruction from the GP when involved in chaperoning. When chaperoning had taken place this was recorded in the patient's records.

Medicines management

The practice was supported by a pharmacist each week, who helped with prescribing audits to ensure patients received appropriate medicines. We saw the 2013/2014 prescribing audit report which identified the positive changes which had been undertaken within the practice. Such as the appropriate read coding of patients who suffered from severe pain, who did not have a cancer diagnosis. These patients would then be readily identifiable, when this information was required.There were appropriately stocked medicine and equipment bags ready for doctors to take on home visits. One doctor's bag was checked and we found the contents were safety sealed and in date.

The GPs told us they received medicine alerts from the Clinical Commissioning Group (CCG), National Institute for Health and Care Excellence (NICE) and Medicines Products Regulatory Agency (MHRA). We saw evidence of the meetings between the GP and the pharmacist and how these alerts were actioned and followed up. We were told where there had been changes to guidelines for some medicines, audits had been completed. Any changes in guidance about medicines were communicated to clinical staff in practice meetings.

Medicine fridge temperatures were checked and recorded daily. The fridges were adequately maintained by the manufacturer and the staff were aware of the actions to take if the fridges were ever found to be out of the correct temperature range. We saw evidence of the practice

following their cold chain policy, as the day before our inspection, there was an electricity outage. They contacted the vaccines supplier and followed the protocol, which was documented.

Cleanliness and infection control

The practice staff appeared to be doing the best they could to keep the practice clean and tidy but the areas used by the practice were in a very poorly maintained condition. For example, the carpets in the waiting room and in the surgeries were heavily stained and thread bare. We also saw the blinds in the surgeries were dirty and dusty and the walls could not be effectively cleaned as they were very badly marked and in some areas bare plaster was showing. We noted that flooring, sinks, taps and tiled surrounds in surgeries did not meet Department of Health guidance.

The manager told us the building had been built in the late 1960s and said the building had last been decorated in the late 1980s. They said the responsibility for maintaining the property was with the landlord, NHS property services (NHS PS) and they were in frequent contact with them to complete essential repair and refurbishment works. We saw evidence the manager had liaised with the landlord about the repairs required and there was written evidence the work had been agreed in November 2013. The manager told us following an unsuccessful tender process for the work in September 2014, a further tender process had commenced in November 2014.

NHS PS commissioned NHS Bradford District Care Trust (NHS BDCT) Estates and Facilities services to clean the building. We saw there were weekly cleaning schedules in place and cleaning records were kept by the staff contracted to clean the building. The manager had put daily room checks in place to monitor the standards and ensure that cleaning tasks within their sphere of control had been completed.

The majority of patients we spoke with and those who completed CQC comment cards had no concerns about cleanliness or infection control.

A practice nurse had a lead role for infection control. Staff received infection control training via electronic learning relevant to their role and received annual updates of the training. When we looked at the training records we saw the majority of staff were in the process of completing the training for 2014/15.

An internal infection control audit had been completed in May 2014 and where shortfalls had been identified an action plan had been implemented and action had been taken but the dates of action had not been recorded. An external audit of the infection control processes had been completed just prior to this inspection in November 2014. The manager told us they had not received an action plan but said they had completed most of the actions required to address the shortfalls that were within their sphere of control, such providing additional sharps containers. Where action was required by NHS BDCT, an action plan had not been provided to indicate when the work would be completed. For example, chairs in surgeries and the waiting areas required replacement as they could not be easily cleaned. The manager said the chairs in the surgeries were the practice responsibility and would be ordered but chairs in the waiting room were NHS BDCT responsibility. Likewise plugs in the surgery sinks required removal but this task could not be undertaken by the practice as it was the property of NHS BDCT.

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. Personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use these to comply with the current infection control guidance. There was a policy for staff to follow in the event of a needle stick injury.

The practice manager was aware of the requirements for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records which confirmed the NHS BDCT had carried out regular checks to reduce the risk of infection to staff and patients.

Equipment

Emergency drugs and equipment were stored in an accessible place. A defibrillator and oxygen were readily available for use in a medical emergency and were checked each day to ensure they were in working condition. Safety notices relating to equipment were displayed appropriately.

We saw equipment had up to date portable appliance tests (PAT) completed and systems were in place for the routine servicing and calibration of equipment, where needed.

Good

Are services safe?

Staffing and recruitment

The practice had a recruitment policy. We looked at the staff file for the most recent staff member employed and found it to be comprehensive and well maintained. All appropriate checks were carried out before the staff member began working within the practice. Clinical staff had recent Disclosure and Barring Service checks (DBS) in line with the recruitment policy. We checked other staff files and found them to be well maintained. They contained appropriate curriculum vitaes and references and sufficient checks to ensure the person was suitable to carry out the duties required in their role. All staff had their clinical qualifications recorded and checked on an annual basis or on renewal of their professional registration.

We saw the locum pack to help support locums when first employed. However we were told the practice tended to use locums they knew and trusted. We saw all locums were thoroughly screened and their details checked prior to employment.

The practice nurses were a support team from Bradford City Care Trust and we were shown the Service Level Agreements (SLA). The nurses had been contracted to the practice for over eight years. In addition we saw evidence of the meetings held.

Staff had appraisal documents available in their files and they told us the process was very supportive. They were able to ask for relevant training for their role. All staff were aware of the policy for study and training leave and told us they were granted study leave in line with this process.

Monitoring safety and responding to risk

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. There were systems in place to monitor safety in the practice and report problems that occurred.

The practice had developed clear lines of accountability for all aspects of patient care and treatment.

Areas of individual risk were identified. Posters relating to safeguarding and violence/ aggression were displayed. The appointment systems allowed for a responsive approach to risk management. For example, we were told by staff and saw information in the practice leaflet appointments were reserved each day for “On the day” emergencies. We were told everyone was seen on the day who presented as an emergency.

Arrangements were in place to protect patients and staff from harm in the event of a fire. This included staff designated as fire wardens and carrying out appropriate fire equipment checks and holding regular fire drills.

There was evidence of learning from incidents and responding to risk had taken place and appropriate changes implemented. The practice 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.

Up to date emergency equipment and drugs were checked and we found they were readily available for use in an emergency. Staff spoken with and records seen, confirmed that all staff had received training in medical emergencies including resuscitation techniques. All staff were trained in basic life support and the clinical staff in the treatment of anaphylactic shock (severe allergic reaction).

Arrangements to deal with emergencies and major incidents

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. The plan included an assessment of potential risks that could affect the day-to-day running of the practice. This provided information about contingency arrangements staff would follow in the event of a foreseeable emergency.

The staff told us the day before the inspection there had been a power cut and they had not been able to access the building. They described how they had implemented the business continuity plan, they said this worked well and they had been able to maintain a service for patients.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients were involved in decisions about their care and treatment. The clinicians were familiar with and were following current best practice guidance. New guidance from the National Institute for Health and Care Excellence (NICE) was reviewed at the regular clinicians' meetings and where appropriate, a plan made to implement into clinical practice. The GP and other clinical staff told us they had access to and followed NHS Bradford City CCG guidelines and care pathways for patients presenting with, for example, abnormal heart rhythms.

We saw patients treatment plans were reviewed in discussion with the GP and appropriate changes made where necessary. This was shared at the practice clinical meetings and multidisciplinary meetings.

From our discussions we found GPs and nurses were aware of the latest best practice guidelines and incorporated this into their day-to-day practices. Protocols from the local NHS trust were available and used to assist staff in maintaining the treatment plans of their patients. The practice used standardised local/national best practice care templates as well as personalised self-management care plans for patients with long-term conditions. This supported the practice nurse to agree and set goals with patients; these were monitored at subsequent visits. There were Bradford specific screening programmes in place, such as diabetes and for hepatitis B and C, to ensure patients were supported with their health needs in a timely way.

The practice raised awareness of health promotion during consultations with GPs and nurses. They also had health promotional literature available in the treatment rooms, the practice waiting areas and were brought to patients' attention through the practice newsletter.

Management, monitoring and improving outcomes for people

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as diabetes and high blood pressure. The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients and was used to monitor the quality of services provided.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes and asthma. The practice had a system in place for completing clinical audit cycles. Examples of clinical audits were seen.

We saw minutes of practice meetings where new guidelines were shared and 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 that staff completed thorough assessments of patients' needs in line with NICE guidance, and these were reviewed when appropriate.

The practice completed full health checks 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 had identified 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 and podiatry clinics and they were involved in the Bradford Beating Diabetes campaign.

Mothers and babies were supported with antenatal clinics, health visitor support and child health and immunisation clinics.

Feedback from patients confirmed they were referred to other services or hospital when required. 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 referral, for instance two week referrals for patients with suspected cancer were done there and then, and other routine referrals were done within seven days.

Effective staffing

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

Good

Are services effective?

(for example, treatment is effective)

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 equality and diversity, health and safety 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. An induction programme included time to read the practice's policies and procedures.

Appraisals were in the process of being updated for all staff. We found staff raised and shared concerns, incidents were reflected upon and learning took place to improve the outcomes for patients.

The GPs who worked in the practice were registered with the General Medical Council (GMC) and were required to undertake regular training and to update their skills. We saw evidence of one of the GPs revalidation and their 360° feedback which was extremely positive from staff, patients and colleagues. The nurses who worked in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must also undertake regular training and updating of their skills.

Working with colleagues and other services

Staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their roles.

The practice used a computer system to store patient records. Staff input data such as discharge letters and blood results into the electronic records. Tasks were then sent electronically for the GP to review the information.

Staff told us they had regular meetings and were able to describe the content of the discussions in the meetings and any actions taken in response. Regular multi-disciplinary meetings were held to discuss patients with complex needs, end of life care and patients at risk.

The practice manager told us they were working with NHS Bradford City CCG on a number of projects. For example, providing extended hours at the practice in response to the 'Winter Pressures Initiative', providing diabetic clinics as part of the Bradford Beating Diabetes campaign. We were also told that the practice was part of a group of 17 practices (Confederation model) in the Bradford City CCG area, who linked together to pool resources and for mutual support. They provided diagnostic ultra sound and warfarin clinics. It is the practice's intention to start 24 hour blood pressure monitoring, in the new year.

Information sharing

Staff had access to electronic systems relevant to their role and all staff had access to up to date practice policies and procedures. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. These included community matron, district nurses, health visitors and palliative care nurses. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

The electronic system enabled timely transfer of information with the out of hours providers and this included the local hospitals. We saw the system in place for managing blood results and recording information from other health care providers including discharge letters. The GP viewed all of the blood results and took action where needed.

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). They confirmed their understanding of capacity assessments and how these were an integral part of clinical practice. They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these

patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were conducted. They told us about the process for requesting and using a chaperone and felt confident that it was effective as it was available to them when needed.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

Patients were supported to live healthier lives. New patients at the practice were given an appointment at registration, which was used as an opportunity to identify potential risks to the patient's health. Patients' individual needs were assessed and access to support and treatment was available as soon as possible.

The practice nurse team led on the management of long-term conditions (LTCs) of the patients in the practice. They proactively gathered information on the types of LTCs patients present with and they had a clear understanding of the number and prevalence of conditions being managed by the practice.

We saw the 'call and recall' system and how this worked within the surgery. This helped to ensure the timely and appropriate review of patients with LTCs and those who required periodic monitoring. Patients with more than one LTC were offered one recall appointment when all care and treatment could be reviewed. This included an appointment time which was longer to improve the patient experience.

We saw information for patients was displayed on notice boards in the practice which included health and social care information leaflets. There was some information provided in languages other than English, for example, information relating to women's health screening. The patient lead within the practice actively sought support information for those with LTCs. They signposted patients to appropriate support groups, which had been visited by the patient lead, this helped the signposting to be more effective.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 3 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 that all consultations and treatments were carried out in the privacy of a consulting room. We saw disposable curtains were provided in all consulting room so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We observed staff were careful when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

There were clearly visible notices in the patient reception area and GP surgeries informing patients they could request a chaperone.

Care planning and involvement in decisions about care and treatment

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. They felt they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. The patient feedback on the comment cards we received was also positive.

Staff recognised when patients who used the practice and those close to them needed additional support to help them understand or be involved in their care and treatment. The staff team were multi-lingual and had access to further interpretation services, when needed.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available. We also saw the practice's winter newsletter had further details about care and support which was available locally.

We were told how the patient lead for the practice supported patients by suggesting they wrote down their concerns about their health to give to the GP at their consultation. The patients we spoke with on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. One told us of the support she and her husband had received from the GP; they felt it was 'over and above expectations'. The CQC patient comments cards also confirmed that all of the practice staff were very supportive to them and their families.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Care and treatment was planned and delivered to meet the needs of patients. Patients we spoke with told us the practice was providing a service that met their needs. The practice regularly sought the views of patients through the patient suggestion box, patient survey and the Patient Participation Group (PPG) which enabled patients to voice their concerns and needs.

The PPG was supported by an identified member of the practice team. They had protected time to contact the members, to encourage other participants and to arrange speakers who would meet the needs of the practice population. They also visited support groups to ensure patients would be signposted appropriately. They encouraged local women's groups to support female patients with issues that were particular to their ethnicity for example concerns about arranged marriages.

Patients with immediate, or life-limiting needs, 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. They also had a dedicated phone line to ensure their concerns could be alleviated as soon as possible. There was a register for patients with learning difficulties and they were offered annual health assessments.

Tackling inequity and promoting equality

Patients who needed extra support because of their complex needs were allocated double appointments. We saw specific tailored care plans to meet their needs for example patients with learning disabilities or those who had long term conditions such as diabetes. The practice worked with the hospital to screen patients for Hepatitis B & C to improve the health of their practice population.

The practice had access to online and telephone translation services and some of the clinical staff spoke languages relevant to the patient population.

The practice provided annual equality and diversity training through electronic learning. We saw from records that staff had either completed this or were in the process of doing so for 2014/15.

Access to the service

The premises had been designed to meet the needs of people with disabilities. For example, the building had level access, parking spaces and toilet facilities for those with a disability and an induction loop system for those who were hard of hearing. The practice was situated within a purpose built health centre with all services for patients on the ground floor.

A range of appointments were available for patients, including telephone consultation with a GP where appropriate, urgent appointments on the same day and home visits. The practice supported patients to access appointments through telephoning the surgery or attending in person. They also had an on-line service to book appointments, although it was used by very few patients. The practice also offered home visits for patients who were unable to attend the practice. The practice opened on Saturday mornings during the winter months to help reduce out of hours pressures. The flexibility the practice had with open access surgeries every Monday and Friday meant clinics could be arranged to link with religious festivals or activities. This helped to maximise the use of appointments, meet the needs of the practice population and minimise out of hours usage. The practice had previously extended opening times and found these did not meet the expectations of the patients currently registered. Patients told us they could access appointments which suited them.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. The practice had received three complaints in the past 12 months; we saw they were responded to as per the practice policy. The practice manager told us all complaints were taken seriously. They had an open door policy for staff and patients so concerns or complaints could be responded to in a timely manner.

The complaints procedure was available to patients in the practice booklet and on noticeboards in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The patients we spoke with were happy with the care they received at the practice and they knew how to make a complaint should they need to. They also felt they would be listened to.

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

There was an established management structure within the practice. The GP and staff we spoke with were clear about their roles and responsibilities. The practice was committed to deliver a service where patient care came first and where they 'were a name not a number'. They wanted to deliver personal services to their patients, which met their needs. However, the practice was aware that their current model maybe unsustainable and they were pro-actively working with the CCG and other practices locally to ensure their vision of primary care continues. They were also very clear about providing a rewarding place to work and ensuring a healthy/work life balance.

Governance arrangements

There was a management structure with clear allocations of responsibilities. Staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had arrangements for identifying, recording and managing risks. We saw 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 team 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.

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment.

Care and treatment was provided by the multi-disciplinary team who met monthly and practice meetings were also held monthly.

Leadership, openness and transparency

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

We saw the minutes of integrated care team meetings, where members of the wider multi-disciplinary teams attended to discuss care and treatment of the patients they supported. Members of this team included social workers, community matrons, palliative care nurse, members from the carers resource team and mental health care workers.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, performance improvement and grievance and disputes 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.

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

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, the number of patients who do not attend for their appointments (DNA), and availability of GPs. We saw actions had been taken such as open access clinics were made available on Monday and Friday. More appointments with the GP were made available and the number of DNAs were displayed for patients to see. The practice newsletter reminded patients to cancel their appointment if not needed. Patients were now being encouraged to consent in writing to receive sms text messages reminding them of their appointment. In addition patients with LTCs were being rung to remind them of their next appointment, in a timely way. All of these measures are working towards ensuring that patients who need to be seen have the opportunity.

The Patient Participation Group (PPG) was actively supported by a named member of the practice team. They held regular meetings where concerns were explored and brought to the GPs attention. We were told issues were attended to in a timely way.

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.

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

We saw that an induction programme was completed by new staff and that all staff had completed mandatory training. This included: fire safety awareness, information governance, safeguarding vulnerable adults and children and equality and diversity. The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. We were told the practice held a record of all training undertaken and details of when refresher training would be required.

Staff told us the training they received helped to improve outcomes for the patients. The staff we spoke with told us they felt supported to complete training and could request any additional training which would benefit their role.

The practice used information such as the Quality Outcome Framework (QOF) & patient feedback to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and share information which was used proactively to improve the quality of services. The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.