

The Avicenna Medical Practice

Quality Report

The Avicenna Medical Practice

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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 inspected this practice on the 18 November 2014 as part of our comprehensive inspection programme.

We found that the practice had made provision to ensure care for people was safe, caring, responsive, effective and well-led and we have rated the practice as good overall.

Our key findings were as follows:

- 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. Risks to patients were assessed and well managed.
- People's needs were assessed and care was planned and delivered in line with current legislation and local care pathways. The practice worked proactively to identify 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 to monitor and improve the health of these patients. Staff had received training appropriate to their roles.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.
- Patients said they had difficulty contacting the surgery by telephone but the practice had put systems in place to try to improve this. Urgent appointments were available the same day.
- There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

There were some areas of practice where the provider needs to make improvements.

- Administration staff had not had disclosure and barring service (DBS) checks completed although some had received chaperone training and may act as a chaperone on occasion.

Summary of findings

- A wide range of information about the practice and services was provided. However, key documents, such as the practice booklet and complaints procedure, were only available in English which did not meet the needs of some of the patient population.
- Verbal concerns that were raised by patients and any actions taken were not always recorded.

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 people safe. However, administration staff had not had disclosure and barring service (DBS) checks completed although some had received chaperone training and may act as a chaperone on occasion.

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

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 (NICE) and used this information routinely. People's needs were assessed and care was planned and delivered in line with current legislation and local care pathways. Staff had received training appropriate to their roles and any further training needs had been identified and planned. 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 to monitor and improve the health of these patients.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that 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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they had difficulty contacting the surgery by telephone but the

Good



Summary of findings

practice had put systems in place to try to improve this. Evidence showed that the practice responded quickly to issues raised and we saw that learning from complaints was shared with staff and other stakeholders.

Written information about the practice and services was available but key documents, such as the practice booklet and complaints procedure, were only available in English.

Are services well-led?

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

Good



Summary of findings

What people who use the service say

Prior to the inspection we received information from the 2013 GP National Patient Surveys. The 54 survey forms returned showed that ratings of patient's experiences of the service they received from the GPs, nurses and reception staff were above the local Clinical Commissioning Group (CCG) average. However their experiences of making an appointment were significantly below the CCG average.

We received 11 CQC comment cards and spoke with three patients on the day of our visit. We spoke with patients from different age groups and with patients who had different physical needs and those who had varying levels of contact with the practice.

The majority of patients who commented were complimentary about the care provided by the clinical staff and the overall service from all staff. Patients said all the staff treated them with dignity and respect. The

majority of patients also told us the clinicians listened to them and were very thorough and caring. The patients said the reception staff were helpful and caring. Patients felt that their views were valued by the staff.

We had some varied comments about the appointments system and its ease of access. Most were complimentary and said they could get an appointment to suit their needs. However other patients told us that they had difficulty contacting the practice in the morning which had led to some patients queuing outside, prior to the practice opening, to try to secure an appointment. We were told by a representative of the patient participation group that this had been identified by the practice. They said additional telephone lines had been installed and extra staff provided which had eased the situation but not completely eliminated it.

The majority of patients told us that the practice was always clean and tidy.

Areas for improvement

Action the service **SHOULD** take to improve

Administration staff had not had disclosure and barring service (DBS) checks completed although some had received chaperone training and may act as a chaperone on occasion.

A wide range of information about the practice and services was provided. However, some documents, such as the practice booklet and complaints procedure, were only available in English which did not meet the needs of some of the patient population.

Although written complaints had been managed appropriately, verbal concerns raised by patients and any actions taken were not always recorded.

The Avicenna Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a lead CQC inspector, a second CQC inspector and a GP specialist advisor.

Background to The Avicenna Medical Practice

The Avicenna Practice is situated in a single storey, purpose built building situated in the centre of a residential area in the inner city area of Bradford. The practice shares the building with three other practices.

The practice provides Personal Medical Services (PMS) for 7042 patients under a contract with NHS England, Bradford. Our information showed that the majority of the patients registered with the practice were in the 0-39 year old age group and numbers in this age group were significantly higher than national average. The practice had a significantly lower than average number of patients in the 50 plus age group. The practice is situated within the most deprived area of Bradford.

The practice is owned by two partner GPs. There has been a significant change in the clinical team in the months leading up to the inspection with two GPs leaving to advance their careers and one GP taking a career break. The practice now has two male partner GPs and one female salaried GP who are supported by locum GPs. An additional salaried GP has been recruited and is due to commence employment in the near future. One advanced nurse practitioner, four practice nurses and two health care

assistants are employed and two additional nurse practitioners have also been recently recruited. An experienced team of administrative and reception staff support the practice. This includes a practice manager, five reception staff and five administrators.

Normal working hours are Monday to Friday 7.30 am – 6.30 pm. The practice is also offering Saturday morning appointments from October 2014 until March 2015. This is as part of the local Clinical Commissions Group (CCG) 'Winter Pressures' initiative to help to ease the pressure on the out of hours service over the winter months.

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).

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.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, 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 four GPs, one practice nurse, a pharmacist and two receptionists and the practice manager. We also spoke with three patients who used the practice including a member of the practice's virtual patient forum.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 11 CQC comment cards where patients and members of the public had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Are services safe?

Our findings

Safe track record

We found that the practice used information from different sources, including patient safety incidents, complaints and clinical audits to identify incidents. The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice.

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 and also in a specific meeting held annually to discuss incidents that had occurred.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice manager provided a summary of the five significant events that had 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 and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, following an incident relating to a patient receiving the incorrect information about blood results the process for advising patients of results had been changed to minimise the risk of a reoccurrence.

We saw records of incidents, investigation and actions taken. We saw that 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 that 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.

National patient safety alerts were disseminated by email to practice staff. The practice manager provided evidence of the emails sent to staff and the records of action taken in response to the alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice manager told us that the staff accessed an electronic learning system for essential training such as safeguarding vulnerable adults and children which was completed annually. The practice manager told us they monitored individual's progress with the training and discussed overall progress at team meetings. We looked at electronic training records which showed that the majority of staff were in the process of completing the training in safeguarding vulnerable adults and children. We saw certificates in staff files that demonstrated some staff had accessed training in previous years. The practice manager evidenced from her training audits that the percentage of staff completing the training in these areas was over 80% in 2013. We were told this was not higher due to staff being on long term sick or maternity leave.

We asked members of medical, nursing and administrative staff about the safeguarding procedures in place at the practice. Staff we spoke with 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 and how to contact the relevant agencies. Procedures and contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. Due to planned changes another GP's was to take over the lead role in safeguarding. They had been scheduled to attend the appropriate level of training.

Patients were able to request a chaperone and notices were visible on the waiting room noticeboard and in consulting rooms. Electronic records showed five staff had completed the annual refresher training to be a chaperone and the remaining staff were in the process of completing this training. We saw from staff files and the practice manager confirmed that administration staff had not had disclosure and barring service (DBS) checks completed although some had received chaperone training. The practice manager told us that the nursing staff or health

Are services safe?

care assistants would act as a chaperone in most circumstances. The practice manager said they had not completed DBS for administration staff as they had felt this was a low risk area as administration staff would not be alone with patients. The practice manager said that they would now ensure DBS checks for administration staff would be completed where chaperone duties were expected as part of their role.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

Medicines management

The management of medicines in the practice was supported by a part time pharmacist. Their role included assisting with quality data collection and monitoring prescribing efficiency.

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 were procedures in place to ensure that medicines were kept at the required temperatures. 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.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. There was evidence that nurses and health care assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

All other prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness and infection control

The practice staff appear to be doing the best they could to keep the practice clean and tidy but the areas used by the practice were in a poorly maintained condition. For example, the carpets in the waiting room and in the

surgeries were heavily stained and thread bare and the blinds in the surgeries were stained. We also observed the walls could not be effectively cleaned as they were very badly marked and in some areas bare plaster was showing. We saw 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 1960's and said the building had last been decorated in the late 1980's. They said the responsibility for maintaining the property was with the landlord, NHS property services (NHS PS) and that 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 that the work had been agreed in November 2013. At our previous inspections in November 2013 and May 2014 we were advised that the landlord had put plans in place to refurbish the building. The manager told us that 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

Are services safe?

but said they had completed most of the actions required to address the shortfalls that were within their control, such as 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 that 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 practice's infection control policy. For example, when receiving samples from patients at the reception. There was also 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 (a bacterium found in the environment which can contaminate water systems in buildings). We saw records which confirmed the NHS BDCT was carrying 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 that 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.

Staffing and recruitment

The practice had a recruitment policy although this did not indicate that registration with professional bodies must be checked. However we did see evidence in staff files that this had occurred in practice.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. Criminal records checks through the Disclosure and Barring Service (DBS) were completed for clinical staff. The practice manager said they had not completed DBS checks for administration staff as they had felt this was a low risk area as administration staff would not be alone with patients. The practice manager said that she would ensure DBS checks for administration staff would be completed where chaperone duties were expected as part of their role. We saw that where a member of staff had moved into a clinical role a DBS check had been completed.

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 staff groups to ensure that enough staff were on duty.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to keep patients safe.

Monitoring safety and responding to risk

The practice had developed clear lines of accountability for all aspects of care and treatment. The GPs and nurses were allocated lead roles in areas such as safeguarding and infection control.

A system was in place to respond to safety alerts from external sources which may have implications or risk for the practice. These included Medicines and Healthcare Products Regulatory Agency (MHRA) and NHS England National Reporting and Learning System. The practice manager told us they ensured alerts were actioned as required and an action log was maintained.

The staff had access to annual training in health and safety, safeguarding vulnerable adults and children, chaperoning patients and fire safety procedures. Procedures to support practice were in place and accessible to staff.

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, a telephone triage system was operated by the GPs.

Are services safe?

Arrangements to deal with emergencies and major incidents

Business continuity plans were in place to deal with emergencies that might interrupt the smooth running of the practice such as power cuts and adverse weather conditions. There were joint working procedures with a nearby pharmacy to ensure business continuity. The staff told us that the day prior to 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.

We found the practice ensured the staff received basic life support and anaphylaxis training. Emergency equipment and medicines were available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). We saw there was a system for the equipment and medicines to be regularly checked. Staff we spoke with confirmed they had received life support training and were aware how to access the emergency equipment. The staff they had emergency call buttons in surgeries and at reception to call for assistance.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their treatment approaches and they had access to and were familiar with current best practice guidance. For example, the staff had access to the National Institute for Health and Care Excellence (NICE) guidance. GPs told us that they had access to and followed local CCG guidelines and care pathways for patients presenting with, for example, abnormal heart rhythms or breathing problems.

We found that patient's needs were kept under review and information relating to patients changing needs was shared at the practice clinical meetings and multidisciplinary meetings.

Patients told us that they felt the GPs listened to them during consultations.

Management, monitoring and improving outcomes for people

Information from the quality and outcomes framework (QOF) showed that the practice was appropriately identifying and monitoring patients with long term health conditions.

The practice had a system in place for completing clinical audit cycles to monitor outcomes for patients following assessment or treatment. Examples of clinical audits included an audit of pneumococcal vaccination uptake in patients over 65yrs over a 12 month period. As a result of the audit, action had been taken by practice to improve this area and a further audit showed increase in uptake from 82.5% in September 2013 to 91% in September 2014. An audit relating to the monitoring of patients weight and cervical cytology for the patients on the combined contraceptive pill had been undertaken between September and December 2013. Actions taken by the practice showed improved recording of patient's weight and an increased number of smear tests being completed for those at risk.

The practice had identified that there was a high prevalence of diabetics in their patient population. To enable them to manage this risk to patients effectively they held regular diabetic clinics and were involved in the Bradford Beating Diabetes campaign. As part of the

campaign, when they identified patients at risk they referred them to one of the Intensive Lifestyle Change Programme (ILCP) groups, which supported people in making changes to their lifestyle. As part of the campaign they also held diabetic clinics for patients who were registered at other practices in the West Yorkshire area. Information about diabetes was provided in languages relevant to the patient population. A patient told us they had been provided with information about the risks of diabetes and healthy lifestyle and diet. Staff involved with the clinics told us they had training in diabetes management.

Staff told us how they had recognised that patients with diabetes had not received podiatry appointments following referral by the practice. They had followed this up and changed the practice work stream to ensure that appointments were booked.

A patient told us their health had been monitored by their GP following an admission to hospital with a serious health problem and they had felt supported by the practice on discharge from the hospital.

Effective staffing

From our review of staff training records and discussions with staff, we found staff completed an induction programme relevant to their role. The practice manager and staff told us that the staff accessed an electronic learning system for essential training such as health and safety, safeguarding vulnerable adults and children, fire and infection control and that essential training was completed annually. However we were not able to verify this or fully establish what training staff had completed and when. We looked at electronically held records and copies of training records in staff files during the inspection to cross reference this with the training log provided by the practice manager prior to the inspection. The training log showed that the majority of staff were in the process of completing the essential training but very few areas had been fully completed for this financial year 2014/15. We saw from the staff files that some staff had accessed training in previous years but we could not establish when the majority of staff had last completed training. The manager was able to produce some figures from her training audits for 2013/14 which showed training completion rates were above 80%. The practice manager told us they monitored individual's progress with the training and discussed progress at team meetings.

Are services effective?

(for example, treatment is effective)

Staff told us they had access to additional training for personal development. For example, one person described how they had been able to develop into a clinical role with access to vocational training and had recently completed accredited training in diabetes via the local university. One member of staff described how they were supervised and their competency was checked following initial training to undertake a clinical procedure.

We saw from a review of staff files that internal annual appraisals were completed for nursing, health care and administration and support staff. Appraisals were completed by their line manager and included the individual's review of their own performance, feedback from the line manager and planning for future development.

We also saw that there was a formal monitoring system in place to ensure that healthcare professionals employed at the service had up to date professional registration with professional bodies such as the Nursing and Midwifery Council (NMC).

Many of the staff had worked at the practice for a number of years and they told us they enjoyed their work and felt well supported.

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 role.

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 GPs 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 the CCG on a number of projects. For example, providing extended hours at the practice in response to the 'Winter Pressures Initiative', providing diabetic clinics for other practices in the area as part of the Bradford Beating Diabetes campaign and working with the CCG to develop health champions.

Information sharing

Staff had access to 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.

The practice worked with other health professionals to share information relating to patient care during regular safeguarding and palliative care multi-disciplinary meetings. The electronic system enabled timely transfer of information with out of hour's services.

Consent to care and treatment

Clinicians we spoke with were able to describe the process for gaining consent to care and treatment. They showed an understanding of mental capacity and issues relating to gaining to consent for both adults and children and were able to give examples of the circumstances in which they had considered a person's mental capacity and the actions they had taken. For example, they were able to describe the care and support they provided for a patient with a life limiting condition to make treatment decisions.

We saw that consent and Mental Capacity Act 2004 was part of the training programme and the majority of staff had commenced this.

Health promotion and prevention

We saw that there was practice web site for patients with links to information provided by organisations such as NHS choices and The Royal college of Psychiatrists. However some health information links on the web site did not work. The practice manager said they would look into this.

We saw that 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. However some information which would be useful for patients, such as the practice leaflet, was only provided in English.

The practice offered a range of services to support patients such as disease management and health promotion clinics which included asthma, diabetes, family planning and routine health checks. The practice also actively promoted local campaigns such as the flu vaccination programme and the Bradford Beating Diabetes campaign. They told us that they actively monitored patient's attendance at clinics

Are services effective?

(for example, treatment is effective)

and followed up non-attendance. They said they had improved the uptake of cervical cytology screening by contacting patients up who did not attend planned appointments and offering them the opportunity to discuss the benefits of screening.

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 patient survey and a survey of patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with the way they were treated. For example, data from the national patient survey showed the practice was well above average for its satisfaction scores on consultations with GP and nurses with 84% of practice respondents saying the GP was good at treating them with care and concern. They were also above the regional average with 88% of respondents saying the last GP they saw or spoke to was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and all but one was 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. One comment was less positive as the patient felt they had not been listened to. 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

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 and 78% felt the GP was good at explaining treatment and results. Both these results were above average compared to CCG area.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. The majority of the patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients whose first language was not English.

Patient/carers support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection said they had received help to access support services to help them manage their treatment and care when it had been needed. The comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately to their care needs.

Staff described how they supported patients with care and treatment to improve outcomes for patients. For example, staff described how they had identified a patient with a long term condition who was not accessing any services. They said they had worked with a GP to explain the condition to the patient and the support available. They told us the patient now accesses regular services.

Notices in the patient waiting room, on the TV screen and patient website informed people how they could access a number of support groups and organisations such as the Alzheimer's Society.

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 people's needs and had systems in place to maintain the level of service provided. However, we found that although the practice patient population included patient's whose first language was not English they did not provide key documents in languages other than English. For example, the practice leaflet and complaints procedure.

The practice held regular clinics for a variety of complex and long-term conditions such as respiratory disease and diabetes. People with long term conditions told us they felt well supported and said that their health condition was well managed. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had identified that the practice patient population were at risk of developing diabetes. They had developed services to enable early identification of those at risk and support for at risk patients to live a healthier lifestyle. They had identified that patients with diabetes were not receiving appointments following referrals to podiatry. They had put processes in place to ensure these patients now received the required appointments. Staff also described how they had identified that a group of patient's required cervical screening. They said they contacted the patients and invited them into the practice to have the procedure performed.

The practice had an active Patients' Forum which met twice a year. We spoke with a member of the forum who told us they had been involved with planning patient surveys and developing an action plan following feedback. They told us the practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example they had identified from their 2014 survey that one of the main issues was the telephone queuing system. In response they had purchased and installed a new call recording system and call queuing system and installed an extra telephone line to improve patient access and reduce call queuing. They had also recruited an additional receptionist to work during busiest time in the morning.

Tackling inequity and promoting equality

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.

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 are hard of hearing. The practice was situated within a purpose built health centre with all services for patients on the ground floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities.

The practice had a mixed population of patients some of whom English was not their first language. Staff had access to translation services and we were told that some of the clinical staff could speak a range of languages including Urdu, Punjabi and Spanish. However key documents were not provided in different languages.

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were not satisfied with appointments system and the practice was well below average for its satisfaction scores. For example, 22% of respondents with a preferred GP said they could usually get to see or speak to that GP; the CCG (regional) average was 43%. Only 35% of respondents said they found it easy to get through to this surgery by phone the CCG (regional) average was 56% and 55% of respondents said they were satisfied with the surgery's opening hours, the CCG (regional) average was 71%.

Are services responsive to people's needs?

(for example, to feedback?)

We found appointments were available from 7.30 am – 6.30 pm on weekdays. The practice was also open on a Saturday morning 9 am – 12 pm between November 2014 and March 2015 as part of the CCG 'Winter Pressures' initiative.

Appointments could be booked up to 5 weeks in advance and there was a telephone triage system for same day urgent appointments. Comments we received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Home visits were available at the GPs discretion. Longer appointments were also available for people who needed them, for example, where the patient required an interpreter.

One person we spoke with and two people who completed CQC comment cards said they had difficulty getting through to the practice on the telephone between 8 am and 9 am. We were told by patients this had created a problem in that patients would then queue outside the practice from 7.30 am to book an appointment. The practice had identified this as an issue and had taken action to improve the telephone system. For example, they had provided an extra telephone line and employed an additional receptionist for the busy periods. There was a mixed response from patients as to whether the changes made had improved the process. For example a member of the patient's forum who had been involved in the development of the action plan said they had seen some improvement in accessing the practice by telephone and they had seen a reduction in patients queuing outside. However, one patient we spoke with said, in the two weeks prior to the inspection, they had tried to make an appointment for their baby but could not get through to the practice. They eventually had to ask the health visitor to make the appointment for them. The manager told us they were continuing to monitor the impact of the changes.

We observed a member of staff having difficulty describing the appointment system to a patient whose first language

was not English. We received varied and conflicting accounts from staff about the percentage of the patients at the practice who did not speak English as a first language. Staff told us this sometimes created a problem when booking appointments. They said due to communication problems they found they were sometimes booking appointments inappropriately. For example, booking an appointment to see a GP for the patient to making a repeat prescription request when this could have been completed at reception. Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and out of hours services.

Listening and learning from concerns and complaints

Patient's we spoke with felt their comments and complaints would be listened to and acted upon without the fear that they would be discriminated against. The practice had a complaints policy and procedure and this was displayed on the notice board in the waiting area, within the practice information leaflet and on the website. There was also a comment box in the patient waiting area. The web site had information for patients on how to escalate a complaint and a link to the NHS complaints web page.

Staff we spoke with were aware of the complaints process and told us how they would support a patient wishing to give feedback. They told us that learning from complaints was shared with them at meetings.

The practice took account of written complaints and comments to improve the service and learning was disseminated at monthly clinical meetings. We looked at the complaints records and responses to patients. We saw the practice had responded to patients in a timely manner and detailed the investigation process and actions taken in the response in line with their complaints policy. However verbal concerns from patients and the actions they had taken in response were not always recorded.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the aims and objective within the practice statement of purpose. This document stated the aims and objectives of the practice were to offer high level clinical and personal care to their practice population. It also said that they aimed to offer a dedicated team of clinical personnel to be able to offer the services in an effective, efficient manner.

We found there was a well-established management structure with clear allocation of responsibilities and all the staff we spoke with understood their role. All the staff we spoke with felt that the practice delivered a high quality of service.

We saw that the practice had developed and published in their practice leaflet a patient charter which set out the service that patients could expect.

We found that the senior management team were aware of the future challenges due to changes in the clinical team but were actively recruiting staff and had plans in place to ensure the continuity of service. A GP told us they hold a half day development meeting every six months to look at plans for the future.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at the policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. The policies and procedures we looked at had been reviewed annually and 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 senior partner was the lead for safeguarding. We spoke with nine members of staff and they 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 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.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audit and review of pneumococcal vaccination uptake by patients over 65yrs had been undertaken over a 12 months period. Action had been taken by practice to improve this area and the audit and review showed an increase in uptake from 82.5% in September 2013 to 91% in September 2014. An audit of effective monitoring of weight and cervical cytology for the patients on combined contraceptive pill had also been undertaken between September and December 2013. Actions taken by the practice in this period showed improved recording of patient's weight and an increased level of cytology tests completed for those at risk.

The practice had robust arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, a fire risk assessment and a legionella risk assessment had been completed.

The practice held a variety of regular meetings in the practice including clinical staff, multidisciplinary and administration staff meetings. We looked at minutes and found that performance, quality and risks were discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that 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, 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.

Are services well-led?

Good 

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

The lead GP told us that in 2013 the practice had received a Good Practice award from the Royal College of General Practitioners (RCGP) and a gold award from Investors in People.

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), telephone queuing system and availability of GP's

We saw as a result of this the practice had completed a number of actions. These included a new call recording system, call queuing system, extra telephone line and telephone in the reception had been purchased and installed to improve patient access and reduce call queuing. They had also recruited an additional receptionist during the busiest time in the morning so that more staff were answering the phones.

They had improved DNA policy and procedure and patients had been sent letters with information guides about the impact of not attending for appointments. They had also changed the numbers of pre-bookable appointments available and send patients text reminders the day before their appointments.

The practice had a virtual patient participation group (PPG) which had steadily increased in size to 35 members. The PPG included representatives from a range of ethnic backgrounds including White British, Pakistani, Bangladeshi, Indian and Polish. The group also included a range of patients with different long term condition groups.

The group had been involved in developing the annual patient survey and in forming the action plan. The results and actions agreed from the surveys were available on the practice website. The manager contacted the virtual group by email, telephone and newsletter.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

Management lead through learning and improvement

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

The practice was a GP and nurse practitioner training practice

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. For example, following an incident relating to a patient receiving the incorrect information about blood results the process for advising patients of results had been changed to minimise the risk of a reoccurrence.