Dr Poonam Jha

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on the 4 November 2014 as part of our new comprehensive inspection programme.

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

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- People received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured people received accessible, individual and compassionate care, whilst respecting their needs and wishes.
- The practice has a clear vision to deliver high quality care and promote good outcomes for patients. We found that the visions and values are embedded within the culture of the practice and are being achieved. There are good governance and risk management measures in place. We found that the provider listens to patient comments and takes action to improve their service.

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 service is safe. Safety was monitored using information from a range of sources. Lessons were learned and improvements were made when things went wrong. Systems, processes and procedures were in place to keep patients safe and safeguarded from abuse. Arrangements for managing medicines were in place. The practice was visibly clean and well-maintained. There were systems in place for the maintenance and use of equipment. Staffing levels and skill mix were planned and reviewed at the practice so that patients received safe care and treatment at all times. The practice safely managed potential risks to the practice.

Are services effective?

Good

The service is effective. Care and treatment was considered in line with current published best practice. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff and services worked together to deliver effective care and treatment. Patients were supported to live healthier lives.

Are services caring?

Good

The service is caring. Patients described to us how they were included in all care and treatment decisions; they were very complimentary about the care and support they received. Patients who used the practice and those close to them were routinely involved in planning and making decisions about their care and treatment. Patients we spoke with told us they received appropriate and timely support they needed to cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The service is responsive to patients' needs. Services at the practice were planned and delivered to take in to account the needs of different patients. Referrals to secondary care and sign posting to services such as Carers Direct, Live Well and Age UK were made in a timely way. Patients spoke positively about the appointment system. Patients' concerns and complaints were listened to and responded to by the practice.

Are services well-led?

Good

The service is well led. Staff understood their roles in achieving a patient focused service. There were systems in place and the practice was improving the way it monitored the way care was

Summary of findings

provided in order to improve the service. Leaders at the practice were visible, approachable and encouraged openness and transparency and promoted good quality care. Patients' and staffs' views and experiences were gathered and acted on to shape and improve the services and the culture of the practice. A proactive approach was taken to involve and seek feedback from patients and staff.

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 made appropriate provision which ensured care for older patients was safe, caring, responsive, effective and well led. The practice had a register of older patients that needed support and these were discussed at the weekly clinical meetings. The community matron reviewed older patients' records weekly and any concerns were updated on a clinical system for the GP. There were systems in place to ensure that older patients had regular health checks and timely referrals were made to secondary care. The practice sign posted housebound or isolated patients to services such as Age UK for additional support. Home visits and longer appointment times were available if patients were attending with a care worker. Older patients were represented on the Patient Participation Group (PPG).

People with long term conditions

Good

The practice made provision to ensure care for patients with long term conditions were safe, caring, responsive, effective and well led. The practice actively reviewed the care and treatment of patients with long-term conditions. We found the GP had a system in place to make sure no patients missed their regular reviews for their condition. Healthcare professionals were skilled in specialist areas and their ongoing education meant they were able to ensure best practice was being followed. Home visits and longer appointment times were available.

Families, children and young people

Good

The practice made provision to ensure care for families, children and young patients was safe, caring, responsive, effective and well led. There were systems in place to identify and follow up on children, young people and families living in disadvantaged circumstances. There was joint working between the practice, health visitors and midwives to monitor patients on the register. An open baby clinic was available once a week for young families. The practice provided childhood immunisations and baby clinics. The practice could produce a register of patients aged 18 and over with learning disabilities.

Working age people (including those recently retired and students)

Good

The practice made provision to ensure care for working age patients and those recently retired was safe, caring, responsive, effective and well led. There was a programme in place so patients did not miss

Summary of findings

their regular review for their condition, such as a diabetic check. Patients told us health promotional advice was offered and material was available on the website. The practice had extended hours until 8.00 pm on a Tuesday and they were open on Saturdays 9.00 am -11.30 am to facilitate attendance for patients who could not attend appointments during normal surgery hours.

People whose circumstances may make them vulnerable

Good

The practice made provision to ensure care for patient in a vulnerable circumstance was safe, caring, responsive, effective and well led. The practice was aware of patients, who were in this group and actively ensured these patients received annual health checks. A psychiatry consultant attended the practice once a week to review all dementia patients. The practice had arrangements in place for longer appointments to be made available where patients required this and access to translation services when needed. There was a system in place to follow up on patients that did not attend their appointment, they would either make a phone call or send a letter to the patient.

People experiencing poor mental health (including people with dementia)

Good

The practice made provision to ensure care for patient who experienced a mental health problem was safe, caring, responsive, effective and well led. The practice recognised and monitored patients who were experiencing mental health needs and patients living with dementia. Clinicians routinely and appropriately referred patients to counselling and appropriate support services, such as Cruse bereavement. There was a system in place for identifying patients who may have poor mental health or dementia. Repeat prescribing for patients receiving medication for mental health needs was monitored by the GP.

Summary of findings

What people who use the service say

We received four completed Care Quality Commission (CQC) patient comment cards and we spoke with five patients on the day of our inspection visit. We spoke with people from different age groups; who had varying levels of contact and varying lengths of time registered with the practice.

The patients spoke very positively of the care provided by staff; their responsiveness to their needs and overall they were always treated with dignity and respect were mentioned. Patients said they were encouraged to be involved and felt supported in the planning and decision making of their care. They felt the clinical staff were engaging and responded to their treatment needs. Patients said staff were dedicated and they were given a caring and compassionate service. Patients told us that the practice was always clean and tidy. Overall they felt the care and quality of the practice provided was very good and they were happy with their care.

Dr Poonam Jha

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead inspector and a GP.

Background to Dr Poonam Jha

Peel Park Surgery is a purpose built health centre with modern facilities located in Bradford and provides primary care services to 2,500 patients. There is disabled access at the front of the practice, a car park with allocated disabled parking spaces and mother and child parking.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening, family planning, maternity and midwifery, surgical procedures and treatment of disease or injury.

The service is provided by one full time female GP and one regular male part time locum. Working alongside the GP is a part time female practice nurse, a part time female health care assistant. There is an experienced management team and 4 administration and reception staff employed to support the practice.

The practice has a Primary Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice.

The practice is open Monday to Friday 8:00 am to 6:00 pm. They also have extended hours until 8.00 pm on a Tuesday and they are open on Saturdays 9.00 am -11.30 am. A range of appointments are available, including telephone consultation with a GP, pre-bookable, on the day appointments, walk in surgery on Monday mornings and urgent appointments on the same day. People are able to book these in person, over the phone or on-line. The practice also offers home visits for patients who are unable to attend the practice. Out of hours services for the practice are directed to Bradford out of hour's service.

The healthcare assistant works in conjunction with the practice nurse to provide clinics for patients at the practice. These include childhood immunisations, travel vaccinations, antenatal screening, diabetes, smoking cessation, Chronic Obstructive Pulmonary Disease (COPD), asthma, chronic kidney disease management, palliative care, health screening, cholesterol and blood sugar testing and cardiovascular care including; anticoagulant dosing, ischaemic heart disease screening prevention and management. The practice also has a patient champion who provides weekly sessions to support patients in weight management, exercise and smoking cessation.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. 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, we always ask the following five questions of every service and provider:

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Families, children and young people
- Working age population (including those recently retired and students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting Peel Park Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We asked the practice to provide a range of policies and procedures and other relevant information before the inspection to allow us to have a full picture of the practice.

We carried out an announced inspection visit on the 4 November 2014. During our inspection we spoke with a range of staff including a GP, a locum nurse practitioner, receptionists and the practice manager. We spoke with patients who used the service including a member of the practice's Patient Participation Group (PPG). A PPG is made up of a group of volunteer patients who meet to discuss the services provided by the practice. We reviewed the CQC comment cards where patients and members of the public shared their views and experiences of the service. We observed positive interactions between staff and patients at the reception area during their visit to the practice.

Good

Are services safe?

Our findings

We looked at how the practice met the safety needs of the population groups. The practice sign posted housebound or isolated patients to services such as Age UK for additional support. The practice held nurse and health care assistant led clinics in areas such as diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) to support patients with such conditions. The practice provided childhood immunisations and baby clinics. There was a programme in place so patients of the working population did not miss their regular review for their condition, such as diabetic, respiratory and heart disease checks. The practice had a system in place to identify patients living in vulnerable circumstances or patients experiencing poor mental health that may be at risk of abuse and follow up actions taken. The GP monitored repeat prescribing for patients receiving medication for mental health needs.

Safe track record

The practice demonstrated it had a safe track record. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that the practice had not received any safeguarding or whistleblowing concerns. Information from the Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety. Safety was monitored using information from a range of sources including QOF, patient survey results, patient feedback forms, NHS Choices, the PPG and clinical audit.

Staff we spoke with were clear and understood their responsibilities to raise concerns, to record safety incidents, accidents, concerns and near misses, and to report them internally and externally where appropriate. They were able to give examples of incidents that had occurred and the process they would follow to report incidents. For example, a system had been put in place to ensure timely referrals were made, reviewed and monitored. The team recognised the benefits of identifying any patient safety incidents.

Learning and improvement from safety incidents

The practice demonstrated that lessons were learned and improvements were made when things went wrong. We reviewed how the practice managed serious or significant incidents. Records showed the system in place was managed in line with guidance issued by the National Patient Safety Agency. There were up to date policies and protocols in place.

We saw evidence that investigations had taken place in relation to these incidents, the action taken and how learning was implemented. We saw minutes of staff meetings, these confirmed incidents were discussed. However, there was no record that learning was shared with relevant staff. Staff we spoke with confirmed they were aware of current incidents and told us how practice had changed as a result.

Safety alerts were reviewed by the practice manager and then emailed to staff and discussed at the practice meetings as appropriate. Copies of the alerts were kept on file.

Reliable safety systems and processes including safeguarding

The practice had reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse. There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The practice had a safeguarding policy in place. The policy detailed the steps that staff members should take if they suspected a person may be at risk from abuse. This included the escalation process within the practice and also provided contact details for external agencies. The staff we spoke with were clear and understood their responsibilities to keep patient safe and how to escalate concerns regarding safeguarding. Safeguarding information was displayed prominently throughout the practice with relevant contact details with external agencies and the action to take in the case of suspected abuse.

The majority of staff had attended training in safeguarding children and adults. The GP and practice nurse had completed safeguarding children levels 2 and 3. The GP was the named safeguarding lead for the practice. The practice had a register in place to identify patients at risk of abuse. These were discussed at safeguarding meetings. The minutes of the meeting confirmed this.

Systems were also in place within the electronic patient records, to alert staff when patients identified as vulnerable adults or children attended for consultation.

Good

Are services safe?

There was an informative safeguarding adults and children's display boards in the waiting room. The practice had a chaperone policy and procedure in place to support patients. All of the reception team had received chaperone training and told us that patients used the service. However, signs were not displayed in the reception and waiting room explaining that patients could ask for a chaperone during examinations if they wanted one.

From our observations during the inspection visit, discussions with patients, staff and from CQC comment cards we found the design, maintenance and use of facilities and premises kept patients safe. We also found the equipment had been calibrated and PAT tested.

Medicines management

The practice had arrangements in place for managing medicines to keep patients safe, which included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal. Medicines were kept in a secure store, which could only be accessed by clinical staff. There were equipment bags ready for doctors to take on home visits. We checked the contents of the bag and found the medication and diagnostics to be in date.

We checked the refrigerators where vaccines were stored. We saw that there were systems in place to check the refrigerators were working at the correct temperatures and records were maintained to evidence this. We looked at a selection of the vaccines stored and found they were within their expiry date.

We saw on the practice web site, practice leaflet and discussions with the practice manager that patients could request repeat prescriptions either by using the reorder form attached to the back of patients script and handing it in at reception or through the surgery post box, or by post. An electronic system gave the GP access to up to date information and best practice guidelines when prescribing medicines for patients.

The practice had a medication review protocol in place. We saw that medicine reviews were carried out, and the practice had a system and protocol in place to alert the GP to when patients were due for a medication review or for do not attends (DNAs). The practice had a system in place to manage and record blood test results. The GP told us that they managed the blood test results and were communicated to patients either by text message or by telephone. There were procedures in place for GP reviews and the monitoring of patients on long term medicine therapy. Patients we spoke with confirmed that they received regular reviews of their medications.

The practice received medication alerts from the Clinical Commissioning Group (CCG) or the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GP and the pharmacist from the CCG. Any changes in guidance about medicines were communicated to staff via an email.

Cleanliness and infection control

Standards of cleanliness and hygiene were maintained at the practice. We observed all areas of the practice to be visibly clean, tidy and well maintained. We saw that the hand washing facilities, liquid soap, paper towels and instructions about hand hygiene were available throughout the practice. Couches were washable and paper couch roll was used. Cleaning schedules were available, they included the frequency of cleaning equipment and areas.

We saw that clinical bins were foot operated and clinical waste was segregated from ordinary waste. We were told the practice did not use any instruments which required decontamination between patients and that all instruments were single use. We observed that the practice had stocks of instruments and that these were within their expiry date. The sharps bins were appropriately assembled signed and dated and were available in all treatment rooms.

The practice had an infection control policy and guidelines in place. This provided staff with information regarding infection prevention and control, including hand hygiene, needle stick injuries waste and dealing with a spillage and bodily fluids. The GP was the lead for infection control in the practice. Audits of the Infection Prevention Control (IPC) processes had been completed internally and externally and an action plan had been developed to address any identified shortfalls.

Equipment

The maintenance and use of equipment kept patients safe. Emergency equipment included a defibrillator and oxygen which was readily available for use in a medical emergency. We saw they had been checked regularly to ensure they were in working condition.

We saw that equipment had up to date portable appliance tests (PAT) completed and systems were in place for routine

Good

Are services safe?

servicing and calibration of equipment where required. The sample of portable electrical equipment we inspected had date stickers on them showing the last time they were tested; each one inspected was in date. Equipment was clean and functional.

Staffing and recruitment

Staffing levels and skill mix were planned and reviewed at the practice so that patients received safe care and treatment at all times. The practice had a staffing policy and procedure in place to maintain quality of care and safety to patients by ensuring they had appropriate skill mix of staff. We discussed with the practice manager how they addressed staffing rotas to provide in-house flexibility and how this was flexible enough to cover unexpected emergencies. The practice review of the rota allowed for sufficient doctors, nursing; healthcare assistants and administration support to be on site at all times. The reception staff said they were flexible and they all helped out when necessary by sharing the workload.

The practice had an effective recruitment policy and procedures in place. Most staff had been employed for a number of years and there was a low turnover and sickness record. We looked at the records for the most recently employed member of staff, and the practice nurse and found this was comprehensive and well maintained. We saw the practice had obtained Disclosure and Barring Service (DBS) checks for all new employees recruited since April 2013 and checks had been undertaken for all clinical staff.

The practice told us they used the same locums for consistency. We saw that appropriate checks had been undertaken which included a GMC reference number, indemnity and a DBS check. The practice had a detailed locum pack in place which gave the GP relevant and up to date information about the practices policies and guidelines, referrals, incident reporting, interpretation services, available clinics, clinical meetings, complaints and chaperone requests, bloods, appointments, sign posting to services such as Macmillan and medication.

Monitoring safety and responding to risk

The practice proactively managed risks. They had developed clear lines of accountability for all aspects of care and treatment. The GP had 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 the CCG. Staff were informed of the alerts via email. Safety alerts were reviewed by the practice manager and then emailed to staff and discussed at the practice meetings as appropriate. Copies of the alerts were kept on file.

Comprehensive risk assessments were carried out for patients who used services. We saw that there were numerous risk assessments in place such as fire, working environment, health and safety, hazardous and non-hazardous waste and Control of Substances Hazardous to Health (COSHH). These were reviewed annually.

Staff demonstrated that they were able to identify and respond to changing risks to patients who used the services in medical emergencies. They told us they had access to emergency equipment.

Arrangements to deal with emergencies and major incidents

Potential risks to the practice were anticipated and planned for in advance. There were effective business continuity plans in place to deal with emergencies that might interrupt the smooth running of the service such as power cuts or loss of computer system. Staff were able to describe the procedure of what they would do in the event that the telephone system went down.

Staff talked confidently about what to do in the event of an emergency. We found all staff were trained in Cardio Pulmonary Resuscitation (CPR) to support patients who had an emergency care need. Emergency equipment was checked and available for staff to access in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We looked at how the practice effectively provided services to the population groups. Health promotional advice and materials were available to maintain older patient's health and independence. The practice had a register to identify and follow up children/young people and families living in disadvantaged circumstances. There was an annual recall system in place for patients with long term conditions. Flexible appointments were available for the working age population. The practice had a register for patients living in vulnerable circumstances. There was a system in place for identifying patients who may have poor mental health or dementia and sign posted patients to services for support.

Effective needs assessment

Patients' needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes. The practice monitored this through an electronic computer system.

The practice also held multiple clinics to meet the needs of the practice population; these included, childhood immunisations, travel vaccinations, antenatal screening, diabetes, smoking cessation, Chronic Obstructive Pulmonary Disease (COPD), asthma, chronic kidney disease management, palliative care, health screening, cholesterol and blood sugar testing and cardiovascular care including; anticoagulant dosing, ischaemic heart disease screening prevention and management.

Patients were supported to achieve the best health outcome for themselves, they had access to information leaflets identifying the rationale for the recommended treatment and also further health promotion advice.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients' care and treatment were routinely collected by the practice. The practice manager told us that this was done through patient survey, NHS Choices website and QOF. We saw that action plans were in place to monitor the outcomes and the action taken as a result to make improvements. Staff were involved in activities to monitor and improve patients' outcomes.

The practice participated in a range of applicable local audits, such as staff training, infection prevention and control and access as well as clinical audits. For example, Pregabalin, cardiovascular, Pioglitazone and Gliptins, inhalers, dysphasia management, adrenaline auto injection, epipens, dermatology, anti-depressants, vitamin D, hypertension and Quinine. We reviewed two of the audits and found the practice was improving the quality of patient care by looking at current practice. The practice were involved in the Clinical Commissioning Group (CCG) access incentive. This involved the practice reviewing and monitoring their appointment flow, for example how many do not attends (DNAs). This incentive highlighted how many appointments the practice should have to meet the population demand and where improvements were required.

The GP had developed a service that was endeavouring to avoid patients having unplanned admissions to secondary care. The aim was to optimise coordinated care for the most vulnerable patients who were frequently seen by the practice. As a result reports were developed to identify patients who were on the practice register without a GP and monthly reviews were undertaken for all unplanned admissions.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. Information from QOF showed that the practice were appropriately identifying and monitoring patients with health related problems.

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. An induction programme included time to read the practice's policies and procedures. We were able to review staff training records and we saw that this covered areas such safeguarding, infection prevention and control, dignity and respect, health and safety, manual handling, fire, information governance and CPR. The practice did not have system in place to monitor when staff were due to attend refresher training. However, staff we spoke with told us that they received refresher training. The practice manager told us that a system would be put in place to monitor refresher training.

Good

Are services effective?

(for example, treatment is effective)

The learning needs of staff were identified and discussed in their appraisals. We viewed staff appraisals and saw evidence of this. Their appraisals were undertaken annually. We looked at three staff appraisals and saw that they were given the opportunity to comment on their progress and training needs for the future. We saw evidence that the practice nurse was supported to maintain their record of Continuing Professional Development (CPD). The GP told us that they were up to date with their revalidation.

Staff told us they also had access to additional training related to their role and for personal development. For example the receptionists were responsible for monitoring the temperature of the vaccination fridges and had undertaken training in maintaining the cold chain. Staff told us that they felt they had opportunities to develop and had protected time to attend courses.

There were arrangements in place for supporting and managing staff to deliver effective care and treatment. There were monthly team meetings where staff could openly raise any concerns or issues and they felt listened to.

Working with colleagues and other services

Staff and services worked together to deliver effective care and treatment. The practice regularly worked with other health and social care providers and professional bodies to co-ordinate care to meet patient's needs, such as Age UK. There were monthly community meetings with the nine practices within the CCG to review patient care and multi-disciplinary teams within the locality. This included district nurses and health visitors. Multidisciplinary meetings were held to discuss patients on the palliative care register and support was available.

Care at the practice was delivered in a coordinated way during out-of-hours care. The practice was supported with the out of hours provision from Bradford out-of-hours service. This assisted with patients who could not access appointments during usual surgery hours to obtain GP treatment. Following the patient use of this service the GP at the practice reviewed any correspondence from them. This ensured the practice was aware of any treatment that had taken place and if any follow up care was needed.

The practice used an electronic system, which enabled staff to complete a number of tasks electronically. This system enabled staff to communicate that a task was required to be completed. For example, referrals and discharge letters were flagged up on the system and tasks were actioned on the same day by the GP. This system also enabled timely transfer of information with out of hours services.

The practice had clear arrangements in place for referrals to other services. The practice manager told us they provided a wide range of in-house clinics to support patients with conditions such as diabetes or asthma. They could also refer patients to other services, such as neuro surgery, maternity, dementia clinics or an exercise referral programme.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were discharged from hospital. We spoke with the GP who told us that they have a telephone consultation with patients three days after a hospital discharge to check there are no problems

The practice had systems 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.

Information sharing

Staff had all the information they need to deliver effective care and treatment to patients who used the practice. All patient information was recorded on an electronic system for staff to access. This ensured all the information needed to plan and deliver care and treatment was shared appropriately and available to relevant staff in a timely and accessible way. There was a system in place to manage information about patients who used the practice to support staff to deliver effective care and treatment.

The patient records at the practice were electronic and which were accessible to staff. Paper records were archived in a lockable cabinet.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff were knowledgeable about how to ensure patients were involved in making decisions and the requirements of the Mental Capacity Act (MCA) 2005 and the Children's Act 1989 and 2004. Staff 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. This is to check whether these patients have the maturity

Good

Are services effective?

(for example, treatment is effective)

(at age 16yrs or younger) to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

The practice manager told us that staff had undertaken safeguarding training which included the MCA.

The practice had an effective consent policy available to assist all staff and there were relevant consent forms for use. People we spoke with confirmed they had been involved and supported in decisions about their care and treatment. They told us their treatment had been fully explained to them and they understood the information given to them.

Health promotion and prevention

Patients were supported to live healthier lives. All new patients at the practice were invited to attend a new patient medical with the practice nurse which was used as an opportunity to identify potential risks to the person's health. Patients' individual needs were assessed and access to support and treatment was available as soon as possible. The practice employed a health trainer to support patients to live healthier lives. The weekly sessions included; weight management, exercise and smoking cessation

QOF information showed the practice performed well regarding health promotion and ill health prevention initiatives. For example, the practice could produce a register of patients over 18 and over with learning disabilities and the practice had regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.

The practice offered national screening programmes, such as bowel cancer, breast cancer and cervical screening. There were also vaccination programmes, long term condition reviews and patients were provided with health promotion information.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering help to support the population groups. The GP was able to tell us how they managed the care of patients with long-term conditions, older patients, patients experiencing poor mental health (including people with dementia), patients in vulnerable circumstances, working age patients (including those recently retired and students) and families, children and young patients; what these were; and the action taken to regularly review their needs. For example patients with long term conditions and patients with a learning disability were on the practice register, patients over the age of 75 received an annual health check. We saw that this knowledge of patients' needs led to targeted services being in place such as the running of diabetic, heart disease and COPD clinics.

The practice provided patients with information about other health and social care services such as bereavement services and patients also had access to an in-house counsellor every Wednesday. We saw a range of informative display boards and leaflets in the practice to signpost patients to these services. The practice website had a health information section. Staff we spoke with were knowledgeable about other services and how to access them. The majority of information was available in English however, there were some available for the Eastern European population. The majority of the staff at the practice were bilingual and could speak in nine different languages such as; Hindi, Urdu, Bengali, Spanish and Italian. Translation services were available and information on the practice website could be translated in to different languages such as Polish, Swahili and Bengali. Patients who attended with an interpreter were provided with a double appointment.

We found the staff proactively gathered information on the types of needs their patients had and staff understood the number and prevalence of different health conditions being managed by the practice. Patients who may be in need of extra support were identified at the practice, for example patients receiving end of life care were placed on the palliative care register.

Good

Are services caring?

Our findings

We looked at how the practice provided a caring service to the population groups. The practice sign posted housebound or isolated patients to services such as Age UK for additional support. Home visits and longer appointment times were available if the patient was attending with a care worker. Confidentiality and privacy was maintained at the practice for all of the population groups.

Respect, dignity, compassion and empathy

Patients at Peel Park Surgery told us they were treated with kindness, dignity, respect and compassion whilst they received care and treatment. They spoke highly about the care they received from all staff at the practice and they felt staff were caring and engaging.

During our observations of the reception area we saw staff treated patients with dignity and respect and ensured conversations were conducted in a confidential manner. Patients could also speak with staff in private in another room if required.

Staff were familiar with the steps they needed to take to protect people's dignity. The practice had an electronic booking in system for those who did not wish to announce their name to the reception staff. The practice waiting room had a range of leaflets available. However the majority were not available in large print or different languages to meet the needs of the practice population.

The practice had a chaperone policy and procedure in place to support patients. All of the reception staff had received chaperone training. However, there were no posters offering the use of a chaperone during consultations and examinations. Staff told us they knew the patients well and could identify the patients that required a chaperone.

We had a number of comments from patients who told us that the GP took time to listen to them and they always got the advice and care they needed. A representative from the Patient Participation Group (PPG) told us that the staff were caring and engaging and the care and quality of the service was very good.

Care planning and involvement in decisions about care and treatment

Patients who used the practice and those close to them were routinely involved in planning and making decisions about their care and treatment. Patients told us that the clinical staff always listen and take action where appropriate. We received comments from patients that they got the advice they needed from the GP and they were also signposted to other services to support them with conditions. Information from QOF showed that the practice had a register for patients who had a comprehensive care plan documented and this was agreed between the patient, their family and/or carers as appropriate.The national GP survey showed that with respect to patients' involvement in decisions about their care, the practice was performing as well as other practices. Seventy-eight percent of patients indicated that their GP was good at involving them in decisions about their care. Eight-four percent said that their GP was a good listener and were satisfied with the care they received

We found that staff communicated with patients so that they understood their care, treatment or condition. We received comments from patients that they understood their treatment and options were discussed during their consultation. Patients from the PPG told us staff at the practice were dedicated and encouraged patients to be involved in their care and the shaping of the services provided by working as a team.

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, and enabled them to access this. Staff had access to some health leaflets in different formats, language line interpreters and the majority of staff were bilingual.

Patient/carer support to cope emotionally with care and treatment

Patients who used the practice told us they received appropriate and timely support they needed to cope emotionally with their care and treatment. They said that they had been signposted to the relevant services to meet their needs.

Staff we spoke with had an understanding of the impact that a patient's care, treatment or condition would have on their wellbeing and on those close to them, both

Good

Are services caring?

emotionally and socially. They said there were various support mechanisms in place to ensure patients were supported, such as bereavement signposting support and in-house counselling services.

The practice had on line information leaflets to down load in different languages, and links to other websites for health related information. For example, self-help guides. Additionally, we saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We looked at how the practice provided a responsive service to the population groups. Home visits and longer appointments were available for older patients attending with a care worker and for patients with long term conditions and patients experiencing poor mental health including patients with dementia. Appointments were available outside of school hours and an open baby clinic was available once a week for young families.

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 that 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 PPG which enabled patients to voice their concerns and needs. The PPG comprised of registered patients and they endeavoured to ensure the group represented the practice population. The group consisted of ten members, including patients with long term chronic disease conditions, older population and mixed sexes. We spoke with one member of the PPG who told us that they were involved and engaged in the decision making of the practice and the practice would listen and act. For example, extended hours on a Tuesday were put into place as a result of the PPG discussion and recommendation

The practice held information about the prevalence of specific diseases. This information was reflected in the plan for the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice held regular clinics for a variety of complex and long-term conditions such as asthma, COPD and diabetes. There were systems in place to ensure that patients were called for routine health checks and non-attendance was monitored and acted on through phone calls or letters to the patient.

The practice made adjustments to meet the needs of patients. There was guidance about using interpreter services and the contact details available for staff to use. Staff were knowledgeable about interpreter services that were available when English was a second language for patients. Staff also told us that they were aware of the patients who may need additional support and when these patients booked an appointment they ensured additional time was allowed for the appointment if required.

The practice provided services which were planned, delivered and coordinated to take account of patient with complex needs or those with a learning disability. The practice manager explained that they involved other agencies to support patients with a learning disability.

Peel Park Surgery was based in a purpose built health centre with modern facilities. We conducted a full tour of the premises and found they were visibly clean and tidy. Patients with mobility difficulties had access to the practice and there were allocated disabled parking spaces. There were also toilets for disabled patients.

Tackling inequity and promoting equality

Services at the practice were planned and delivered to take in to account of the needs of different patients. Patients living with dementia or patients with learning disabilities were on the practice register and they reviewed regularly by the GP. They could attend with either a relative or carer and double appointments were available.

The practice had a register of patients on an electronic system who were in vulnerable circumstances. Patients' electronic records contained alerts for staff; for example patients who were at risk of abuse. The practice referred patients to Age UK or a dementia clinic which offered support with drug/alcohol misuse and mental health.

The staff said they had a good relationship with patients and they knew them well.

The practice had made adjustments so that disabled patients and patients with push chairs could access and use services on an equal basis to others.

Access to the service

Patients could access care and treatment at the practice in a timely way. The national GP survey showed that the practice was performing as well as other practices with respect to patients' responses regarding telephone and appointment access. Eighty-eight percent of patients said they were satisfied about telephone access and the process for booking an appointment and 97 percent said their last appointment was convenient for them.

A range of appointments were available, including telephone consultation with a GP, pre-bookable, on the day appointments, walk in surgery on Monday mornings and urgent appointments on the same day. People were able to

Are services responsive to people's needs?

(for example, to feedback?)

book these in person, over the phone or on-line. The practice also offered home visits for patients who are unable to attend the practice. Out of hours services for the practice were directed to Bradford out of hours service.

Effort was made to offer a wide range of appointment options to enable patients to access care and treatment at a time to suit them. The practice was open Monday to Friday 8:00 am to 6:00 pm. They also had extended hours until 8.00 pm on a Tuesday. The practice was also open on a Saturday 9.00 am – 11.30 am. The practice manager told us that they never cancelled GP appointments and when there were delays patients were kept informed about any disruption.

Patients attending the practice could alert staff of their arrival by registering on an electronic touch screen monitor situated in reception or by notifying the staff at the desk.

Listening and learning from concerns and complaints

Patients' concerns and complaints were listened to and responded to and used to improve the quality of care at the practice. The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Complaints were handled in line with the practice policy. The outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings. Staff we spoke with told us that through the analysis of complaints at the meetings they learned how to do things differently at the practice

There were systems in place for reporting and receiving complaints. We reviewed the record of complaints for the practice and saw that there had been two complaints within the last 12 months. There was a full audit trail of the process which included a summary, actions taken, learning and next steps. We saw evidence that the patients were involved in the complaints investigation process and invited to attend a meeting with the practice manager.

The complaints procedure was available to patients in the practice booklet. The patients we spoke with were very happy with the care they received at the practice and they knew how to make a complaint should they need to.

Are services well-led?

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

Our findings

The culture of the practice was centred on the needs and experience of patients that used the service.

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 vision and practice values within the practice statement of purpose. This document stated the overall purpose of the practice was to improve the health, wellbeing and lives of those patients they care for. The practice also had a patient charter, explaining what patients can expect from the service and what the practice expects from the patients.

Patients were encouraged to be involved in decision making. The Practice engaged with patients in various ways, including Patient Participation Group (PPG). We saw from the PPG and staff meetings, including the practice protected learning time training days that patients and staff were involved in developing and achieving the vision of the practice. The practice were in the process of developing a "Virtual Patients Group" to provide any patients that cannot be physically present to have a voice.

Staff at the practice were supported by the GP and the practice manager. The practice manager had an open door policy whereby if staff had any issues or concerns they could speak with either the practice manager or GP for advice.

Governance arrangements

The practice had a governance framework to support the delivery of the strategy and quality care. The practice manager's role involved overseeing that the systems in place were consistently being used and were effective.

The practice had an effective governance framework to support the delivery of the strategy and good quality care to patients. The practice manager took an active leadership role in overseeing that the systems in place were consistently being used and were effective. The practice had policies and procedures to govern activity and which were accessible to staff. The practice manager, GP and staff we spoke with were very clear on their roles and responsibilities and they understood what they are accountable for. We found that the team were allocated lead roles, for example the GP was the lead for safeguarding and infection prevention and control and the reception staff were allocated the role of chaperones.

Clinical and internal audit were used to monitor quality and systems to identify where action should be taken. For example prescriptions were audited every 6 months.

Leadership, openness and transparency

Leaders at the practice were visible and approachable, encouraged openness and transparency and promoted good quality care. Staff we spoke with confirmed that the managers were approachable, always there to provide support or give advice, they were friendly and that they had a good working relationship with them. They said they were able to discuss any concerns or issues with the management team. The practice manager said their door was always open to staff if they needed support or advice. Staff told us they felt supported, respected and valued as a team member by the management team at the practice.

The culture of the practice was centred on the needs and experiences of patients who used the services. Staff told us that they always focused on the patient's needs. From discussions with staff, it was clear that patient safety was embedded within the culture of the practice. Staff told us that they always put the patient first.

The practice actively sought the views of the patients through the PPG, patient survey and the patient comments box. As a result of patient feedback the practice displayed DNAs (do not attends) on the health promotion television in the reception area to inform patients and aim to reduce DNAs by patient awareness.

The culture encouraged candour, openness and honesty, with regular meetings and where challenge and debate was encouraged. All staff attended staff meetings and they told us that they were encouraged to voice their opinions and felt listened to. The minutes of the meetings reviewed showed that quality and safety for patients was a priority, that they regularly reviewed changes to improve practice and staff had an opportunity to discuss how the service was being delivered. We viewed the minutes from the protected learning time staff attended which showed that staff were actively involved in the decision making of the practice. The minutes of the meeting included staff ideas to improve the service. For example, one suggestion made to improve the delivery of test results to patients was to have

Are services well-led?

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

embargoed slots between 10.00 am and 11.00 am for patients. The PPG member we spoke with told us the practice was dedicated and encouraged patients to be involved. They said they were listened to and involved in the decision making to inform how the practice could best meet the needs of their patient groups. For example, the practice introduced walk in clinics as a result.

The practice recorded the majority of meetings which took place, however they did not provide a full audit trail of areas discussed and action taken. The weekly clinical meetings were not minuted.

Staff safety and wellbeing was a priority for the practice, including monitoring of hours worked by staff to ensure it was not excessive. Staff we spoke with told us that their wellbeing was good and they were looked after by the management team and they supported each other as a team.

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

Patient's and staffs views and experiences were gathered and acted on to shape and improve the

Service's and the culture of the practice. The practice had a PPG which contributed to decisions for improving services. The practice manager said they actively encouraged the PPG to be involved in decision making. The practice had conducted a patient survey, we saw that an action plan was in place and improvements were on-going.

We received four completed Care Quality Commission (CQC) comment cards. The patients were complimentary about the care provided by the staff that it was a good service.

Staff were very engaged with and committed to the practice and its patients. They spoke passionately about their roles and the patients and how they were supported to give patients the best care possible

Each member of staff we spoke with felt they had a voice and the practice was interested in creating a learning and supportive working environment.

Staff understood the value of raising concerns and they were able to raise these with the practice manager or GP. They felt that they would be listened to and action taken where appropriate.

Management lead through learning and improvement

The practice used information to continuously improve the quality of services. Staff were able to take time out to work together to resolve problems and information which was used to proactively to improve the quality of services.

The staff we spoke with told us they felt supported to complete training and could request any additional training which may assist with their role. For example, the reception staff were due to attend recoding and choose and book training to support them in their roles. Staff also had their own training schedules in place for any further training and updates required by the practice. We saw that an induction programme was completed by new staff and that the majority of staff had completed mandatory training. The mandatory training for staff included areas such as; fire safety, information governance, safeguarding and dignity and respect. The practice did not have system in place to monitor when staff were due to attend refresher training. However, staff we spoke with told us that they received refresher training. The practice manager told us that a system would be put in place to monitor refresher training.