

Conway Medical Centre

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?		Requires improvement	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Conway Medical Centre on 11 and 12 January 2017. Overall, the practice is rated as good, however it is rated as requires improvement for the safe domain. Our key findings across all the areas we inspected were as follows:

- The practice had recently reviewed and updated the majority of their policies and procedures. A signatory sheet had been introduced to ensure all staff signed to say they had read and understood them.
- Staff understood their responsibilities to raise concerns. We saw evidence of investigation, actions and shared learning from those incidents which had been reported. However, it was unclear whether all incidents and near misses had been reported and recorded in the absence of a permanent practice manager. We were assured that systems had been recently reviewed to ensure all incidents were being recorded and staff had been reminded to report any incidents or near misses.
- Some risks to patients were assessed and well managed. However, it was not clear how patient safety alerts had been dealt with prior to the locum practice manager being in post. A system had since been implemented to action all relevant alerts.
- There were health and safety risk assessments in place, including fire risk. Not all staff were up to date with fire safety training. However, we were assured that staff knew what to do in such an event and that training had been arranged for staff to complete by the end of January 2017.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- A health trainer was available in the practice on a weekly basis, to provide additional support for patients regarding lifestyle choices, health advice and signposting to other appropriate services.
- The most recently published national GP patient survey results showed patient satisfaction rates with

Summary of findings

the practice were lower than average. However, a practice based survey and patient comments we received on the day, were positive about the service and care they received.

- Data showed patient outcomes were in line with local and national averages.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Staff had a good understanding of their practice population and the majority were multilingual in languages suitable to the needs of their patients.
- We saw that staff were dedicated to improving the quality of care and were positive about any changes which were being made to achieve this.

The areas where the provider must make improvements are:

- Ensure all Patient Group Directions (PGDs) are signed by the nursing staff who are administering vaccines and medicines; in line with the latest legislation.

In addition the provider should:

- Support staff to keep up to date with mandatory training in accordance with current guidelines.
- Improve record keeping from practice, clinical and multidisciplinary meetings.
- Continue to implement, review and maintain the systems and processes which are used to govern the practice and ensure the safety of patients.

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 requires improvement for providing safe services.

Requires improvement



- Staff understood their responsibilities to raise concerns. However, it was unclear whether all incidents and near misses had been recorded in the absence of a permanent practice manager. We saw that the locum practice manager had difficulty accessing previous electronic reporting due to security issues. We also saw evidence of investigation, actions and shared learning from those incidents which had been reported. We were assured that systems had been recently reviewed to ensure all incidents were being recorded and staff had been reminded to report any incidents or near misses.
- There was a nominated clinical lead for safeguarding children and adults and processes in place to keep patients and staff safeguarded from abuse. All staff had been trained to the appropriate level in safeguarding.
- There was evidence of Patient Group Directions (PGDs) however, at the time of inspection, they had not been signed by the nursing staff who were administering vaccines and medicines.
- Some risks to patients were assessed and well managed. However, it was not clear how patient safety alerts had been dealt with prior to the locum practice manager being in post. A system had since been implemented to action all relevant alerts.
- Health and safety risk assessments had been undertaken, however, a legionella risk assessment was overdue. We saw evidence that a date had been booked for this to be undertaken on the 25 January 2017 and that staff were undertaking water flushing and temperature recordings to reduce any potential risks.
- The practice had faced some challenges in maintaining systems and processes needed for the management of the practice and to ensure safety of patients. We were informed that not having a permanent practice manager, reduced GP availability and a reliance on locum nursing staff had been contributing factors. We saw evidence of recently implemented systems and policies. The practice informed us they were taking action to continue to improve.

Summary of findings

Are services effective?

Good



The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in line with local and national averages.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- We saw evidence of clinical audits, based on clinical guidance, which could demonstrate quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff were up to date with mandatory training, with the exception of fire safety. However, they understood what their responsibilities were in such an event. We were informed that training had been arranged for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- A health trainer was available in the practice on a weekly basis, to provide additional support for patients regarding lifestyle choices, health advice and signposting to other appropriate services.
- Services were provided to support the needs of the practice population, such as screening and vaccination programmes, health promotion and preventative care.
- End of life care was coordinated with other services, such as the palliative care team.

Are services caring?

Good



The practice is rated as good for providing caring services.

- We observed that staff treated patients with kindness, dignity, respect and compassion. Patients' comments we received as part of the inspection aligned with these observations.
- Data from the National GP Patient Survey showed patients rated the practice lower than others for some aspects of care. However, the patient comment cards we received and the practice patient survey they had undertaken stated that patients felt their care was good.
- Information for patients about the services available was easy to understand and accessible. Some were available in different languages. Many of the practice staff were multilingual in languages befitting patients' needs. Interpretation services were also used when required.
- The practice offered a home visit for those families who had experienced bereavement.

Summary of findings

- The practice held a carers' register and provided health checks and influenza vaccinations. For these patients. They were also signposted to other organisations and groups for additional support.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice worked with Leeds South and East Clinical Commissioning Group (CCG) and other local practices to review the needs of their population.
- The practice offered pre-bookable, same day and online appointments. They also provided telephone consultations and text message reminders. All patients requiring urgent care were seen on the same day as requested.
- Home visits and longer appointments were available for patients who were deemed to need them, for example housebound patients or those with complex conditions.
- Extended hours were available each Monday and we saw evidence that patients were often 'fitted in' when necessary.
- The national GP patient survey showed patient satisfaction scores were lower than national averages. However, patients' comments we received on the day of inspection were positive about access to appointments and services.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients had access to male and female clinicians.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led.

Good



- There were governance arrangements in place, which were undergoing a review. These included the identification of risk and policies and systems to minimise risk. The majority of policies and procedures had recently been reviewed and updated. A signatory sheet had been introduced and we saw that all staff had signed to say they had read and understood the policies.
- The provider complied with the requirements of the duty of candour. There were systems in place for reporting notifiable safety incidents and sharing information with staff to ensure appropriate action was taken.

Summary of findings

- The practice promoted a culture of openness and honesty. Staff were encouraged to raise concerns, provide feedback or suggest ideas regarding the delivery of services.
- There was a vision to deliver high quality care and promote good outcomes for patients.
- There was a strong patient-centred ethos amongst the practice staff and a desire to provide high quality care. This was reflected in their passion and enthusiasm when speaking to them about the practice, patients and delivery of care.
- There had previously been a patient participation group (PPG). Ex-members of the PPG told us there had been good engagement with the practice. We were informed by the practice of the plans to reinstate the PPG in the near future.

Summary of findings

The six population groups and what we found

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

Older people

Good



The practice is rated as good for the care of older people.

- The practice provided proactive, responsive care to meet the needs of their older patients. Home visits, longer or urgent appointments were available for those who needed them.
- The practice worked closely with other health and social care professionals, such as the district nursing team, to ensure housebound patients received the care and support they needed.
- Care plans were in place for those patients who were considered to have a high risk of an unplanned hospital admission and patients were reviewed as needed.
- Annual health checks were offered for all patients over the age of 75. These were used to assess a patient's social, physical and psychological health and wellbeing.
- Older patients were provided with advice and support to help them to maintain their health and independence for as long as possible.
- Shingles, pneumococcal and influenza vaccinations were offered to eligible patients.
- The practice were able to identify at an early stage older patients who may need palliative care as they were approaching the end of life. Patients were involved in planning and making decisions regarding their care.

People with long term conditions

Good



The practice is rated as good for the care of people with long term conditions.

- The practice had a register of patients who had a long term condition. These patients were invited for an annual review to check their health care and treatment needs were being met.
- Regular medication reviews were undertaken, particularly with those patients who were prescribed multiple medications.
- The practice delivered care and support for some patients using an approach called the House of Care. This approach enabled patients to have a more active part in determining their own needs in partnership with clinicians. It was currently used with patients who had chronic obstructive pulmonary disease (COPD), diabetes or a high risk of diabetes.

Summary of findings

- 50% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months (CCG average 87%, national average 90%).
- 68% of patients diagnosed with asthma had received an asthma review in the last 12 months (CCG and national averages of 75%).
- 76% of patients diagnosed with chronic obstructive pulmonary disease (COPD) had received a review in the last 12 months (CCG average 88%, national average 90%).
- We were informed that due to the impact of a reliance on locum nursing staff this had affected the numbers of reviews which had been undertaken previously. However, the practice assured us this was currently being addressed. We saw evidence of patients being on a recall and review system and an improvement on the 2015/16 review rates.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- Patients and staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. All children and pregnant women who required an urgent appointment were seen on the same day as requested.
- The practice worked with midwives, health visitors and school nurses to support the needs of this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were comparable to local and national uptake rates for all standard childhood immunisations.
- Meningitis vaccinations were offered to teenagers and university students in line with the national programme.
- Any children or young person identified as needing extra support were seen by a GP and referred to appropriate children's services, such as a local mental health charity. This service provided support and advice for both the child and their family during periods of anxiety, worry, bullying or other mental health issues.

Good



Summary of findings

- All children and young people at risk of a safeguarding issue or deemed vulnerable were flagged on the practice computer system. These included those who were in families where domestic abuse was known.

Working age people (including those recently retired and students)

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

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided extended hours appointments one evening per week, telephone consultations, online booking of appointments and ordering of prescriptions.
- The practice offered a range of health promotion and screening that reflected the needs for this age group. This included screening for those patients at risk of diabetes.
- Health checks were offered to patients aged between 40 and 74 who had not seen a GP in the last three years.
- Students were offered public health recommended vaccinations prior to attending university.
- Travel health advice and vaccinations were available.
- Those patients who had problems with housing, debt or isolation were referred to other agencies as appropriate (this is also known as social prescribing).

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- Staff knew how to recognise signs of abuse in patients whose circumstances may make them vulnerable. For example, young girls who were at risk of FGM (female genital mutilation). Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Patients who did not attend their appointments were contacted and supported to access care and treatment as needed.

Good



Summary of findings

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example MARAC (multi-agency risk assessment conference - a meeting of professionals to support people at high risk of serious harm).
- A register was maintained of all patients who had a learning disability. All these patients were invited for an annual health review.
- Patients' records were flagged to alert staff to a patient who may be vulnerable. This also included those patients known to encounter domestic abuse. In those instances, children were also flagged as being vulnerable.
- Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- Longer appointments were available for patients in this group as needed.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health team and social services.
- Systems were in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- Patients who were at risk of developing dementia were screened and support provided as necessary. Data showed that 75% of patients diagnosed with dementia had received a face to face review of their care in the preceding 12 months (CCG average 87%, national average 84%). Personalised care plans were in place for these patients.
- Staff could demonstrate how to support patients with mental health needs or dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 100% of patients who had a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses, who had a comprehensive, agreed care plan documented in their record in the preceding 12 months (CCG and national averages of 88%).

Good



Summary of findings

- Longer appointments were available for patients within this group.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. A total of 348 survey forms were distributed, of which 62 were returned. This was a response rate of 18% which represented less than 3% of the practice patient list. The percentage results from respondents showed the practice was performing below local and national averages. For example:

- 62% described their overall experience of the practice as good, compared with the CCG average of 82% and the national average of 85%.
- 42% said they would recommend this practice to someone who has just moved to the local area (CCG 75%, national 78%)
- 55% described their experience of making an appointment as good (CCG 69%, national 73%)
- 73% said they had confidence and trust in the last GP they saw or spoke to (CCG 95%, national 95%)
- 79% said they had confidence and trust in the last nurse they saw or spoke to (CCG 98%, national 97%)

We spoke with the practice regarding their low patient satisfaction scores. We were informed that they had recently undertaken their own patient survey and had identified actions arising from that. These were mainly regarding appointments, rather than how they were

treated and cared for; patients appeared to be happy with the clinicians. The practice were currently in the process of addressing those issues raised across both patient surveys. For example, increasing the number of preferred GP appointments, increasing the length of appointments for those patients who required interpreter/translation services and exploring how they could improve patient satisfaction overall.

As part of the inspection process we asked for Care Quality Commission (CQC) comment cards to be completed by patients. On the day of inspection we had received 17 comment cards. All were positive, many using the words 'excellent' and 'friendly' to describe the staff, the service and care they received. Several commented on how they found it easy to get an appointment.

We spoke with four patients and their views and comments about the practice also aligned with those on the comment cards received. Some of the patients had been members of the patient participation group (PPG) and informed us how the practice had previously engaged with them. They also expressed an interest in reactivating the PPG. The practice informed us they were intending to reinstate PPG meetings in the very near future.

Areas for improvement

Action the service **MUST** take to improve

- Ensure all Patient Group Directions (PGDs) are signed by the nursing staff who are administering vaccines and medicines; in line with the latest legislation.

Action the service **SHOULD** take to improve

- Support staff to keep up to date with mandatory training in accordance with current guidelines.

- Improve record keeping from practice, clinical and multidisciplinary meetings.
- Continue to implement, review and maintain the systems and processes which are used to govern the practice and ensure the safety of patients.

Conway Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and included a GP specialist adviser.

Background to Conway Medical Centre

Conway Medical Centre is a member of the Leeds South and East Clinical Commissioning Group (CCG). Personal Medical Services (PMS) are provided under a contract with NHS England. The practice has signed up to a number of local and national enhanced services (these services require an enhanced level of service provision above what is normally required under the core GP contract). These services include participating in the childhood vaccination and immunisation scheme; providing influenza and pneumococcal vaccinations; provision of extended hours access; blood borne virus and latent TB infection screening.

The practice is located at 51-53 Conway Place, Leeds LS8 5DE, which is situated within the Harehills district of Leeds. The premises were purpose built and are owned by the GP and her husband (who also works as a salaried GP at the practice). All patient areas and consulting rooms are on one level. There is disabled access and a car park to the rear.

On a scale of one to ten, the practice deprivation score is ranked by Public Health England as being one. (One represents the highest levels of deprivation and ten the lowest. Practices who have high levels of deprivation often face the most challenges in primary care.)

The patient list size is currently 2,339, the vast majority of whom are of Asian origin. There are a small number of patients who are white British or Romanian. The practice

informed us that there are many patients who are non-English speaking. However, the majority of staff are multilingual befitting the languages used by the patient population. The practice has higher numbers of patients who are in the birth to 49 age range, compared to local and national averages. There is also a higher percentage of male patients than female patients. The percentage of patients who have a long standing health condition is 66%, compared to 55% locally and 53% nationally. The number of patients who are in paid work or unemployed is in line with local and national trends.

The clinical team consist of the female lead GP, a male salaried GP, a locum advanced nurse practitioner and a locum practice nurse (both of whom are female). They are supported by a team of three reception and administration staff; one of whom also works as a part-time healthcare assistant within the practice. A cleaner/housekeeper is also employed by the practice.

The practice is open between 8.30am to 6pm Monday to Friday. There are extended hours on Mondays from 6pm to 7.45pm. Morning appointments are 9.30am to 12.30pm every weekday. Afternoon sessions are Mondays 4.30pm to 7.30pm, Tuesday 4pm to 5.30pm, Wednesday and Friday 3.40pm to 5.30pm. Although the practice is open to patients on Thursday afternoons there are no clinical sessions in operation. When the practice is closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

Dr Mansoor had previously been in a partnership but that had ceased mid-2016. She was now registered with the Care Quality Commission as a single handed practice. Since the departure of their employed practice manager, the practice had been supported for a period of time by practice managers from local GP practices. At the time of inspection Dr Mansoor was in the process of forming a

Detailed findings

partnership with two local GPs. These two GPs (one male, one female) had commenced working some sessions at the practice. The practice manager and a practice nurse from their practice had also been supporting the practice since November 2016.

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations, such as NHS England and Leeds South and East Clinical Commissioning Group (CCG), to share what they knew about the practice. We reviewed the latest 2015/16 published data from the Quality and Outcomes Framework (QOF) and the latest published national GP patient survey results (July 2016). We also reviewed policies, procedures and other relevant information, which the practice provided before and during the day of inspection.

We carried out an announced inspection on 11 and 12 January 2017. During our visit we:

- Visited the practice location at 51-53 Conway Place, Leeds LS8 5DE.
- Reviewed questionnaire sheets which were given to reception/administration and nursing staff prior to inspection.

- Spoke with a range of staff, which included Dr Mansoor, the salaried GP and a GP who was going into partnership with Dr Mansoor; a locum practice nurse, the locum practice manager and reception/administration staff.
- Spoke with patients and reviewed CQC comment cards where patients shared their views and experiences of the practice.
- Observed in the reception areas how patients/carers/family members were treated.
- Looked at information the practice used to deliver patient care and treatment. This included looking at a sample of personal care or treatment records of patients.

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

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

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There were systems in place for reporting and recording significant events and dealing with safety alerts.

- Staff understood their responsibilities to raise concerns and told us they would inform the practice manager or lead GP of any incidents. There was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Due to the absence of a permanent practice manager, it was unclear whether all incidents and near misses had been recorded on the electronic reporting system over the previous two years. We saw that the locum practice manager had difficulty accessing previous electronic reporting due to security issues. However, we saw evidence where the GP had kept written records of incidents, which had subsequently been recorded electronically by the locum practice manager. We saw evidence of investigation, actions and shared learning from those incidents which had been reported. For example, a prescription had been issued for the wrong patient, as a result of them having the same name. This had resulted in the practice raising awareness with staff to ensure they checked date of birth and address of patients. A 'flag' was also inserted onto the electronic record of patients who had the same name. We were assured that systems had been recently reviewed to support the recording process and that staff had been reminded to report any incidents or near misses.
- We saw evidence that if anything had been amiss regarding care and treatment, patients had been informed of the incident as soon as reasonable practicable. We were informed they had received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- All recorded significant events relating to medicines were monitored by the local CCG medicines management team. Any concerns or issues were then fed back to the practice to act upon.

- We saw evidence that the locum practice manager had recently implemented a process to cascade and action national and regional safety alerts. Again, it was unclear what had happened during the period where there was an absence of a permanent practice manager.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep people safe and safeguarded from abuse. We saw evidence of:

- Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. There were laminated posters displaying safeguarding information and contact details in all the consulting and treatment rooms and in the reception area. Staff had received training relevant to their role and could demonstrate their understanding of safeguarding. The GP acted in the capacity of safeguarding lead and had been trained to the appropriate level three. We were informed that regular meetings were held with the health visitor and any safeguarding issues/concerns were communicated to them. However, documented minutes were not held of the meetings. The practice informed us they would commence keeping a record of any future meetings. In addition, we saw evidence of communication with the local MARAC (multi-agency risk assessment conference) regarding those patients who had a high safeguarding concern.
- A notice was displayed in the waiting room, advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We saw up to date cleaning schedules in place. There was a nominated infection prevention

Are services safe?

and control (IPC) lead and an IPC protocol in place. All staff were up to date with IPC training. We saw evidence that an IPC audit had taken place and action had been taken to address any improvements identified as a result. For example, recording regular flushing of taps and water temperatures. In addition, the healthcare assistant did a monthly room audit and any issues identified were addressed.

- There were arrangements in place for managing medicines, including emergency drugs and vaccinations, to keep patients safe. These included obtaining, prescribing, recording, handling, storage and security.
- Processes were in place for handling repeat prescriptions, which included the review of high risk medicines. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines, in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) However, at the time of inspection, these had not been signed by the locum practice nurse. We were informed the practice would take measures to rectify this. The healthcare assistant did not administer vaccines or medicines.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment at that time. The administration/reception staff had been in post many years and the most recently employed member of staff had been recruited 10 years ago. We were informed that any new staff would be recruited under the recently reviewed practice policy, which identified pre-employment checks such as DBS checks, references, proof of ID and qualifications.

Monitoring risks to patients

The practice had recently reviewed and implemented procedures in place for assessing, monitoring and managing risks to patient and staff safety. We saw evidence of:

- A health and safety policy and risk assessments to monitor the safety of the premises, such as control of substances hazardous to health (COSHH). We were informed that a legionella risk assessment was booked for 25 January 2017. However, there were records to show that regular flushing of taps and water temperatures were being undertaken in the meantime to reduce any risks. (Legionella is a bacterium which can contaminate water systems in buildings.)
- A recent fire risk assessment, fire alarm testing and fire evacuation plan (this had recently been tested out by staff). Staff could demonstrate they knew what to do in the event of a fire, however, not all staff were up to date with their fire safety training. We were informed that training had been organised for staff to complete before the end of January 2017.
- All electrical and clinical equipment was regularly tested and calibrated to ensure the equipment was safe to use and in good working order.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff worked flexibly to cover any changes in demand, for example annual leave, sickness or seasonal.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. We saw:

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff were up to date with basic life support training.
- There was a defibrillator, however, no oxygen was kept on the premises. We were informed that oxygen had been ordered prior to the inspection and saw the invoice to confirm it would be delivered before the end of January 2017.
- We were informed that the GP may take a selection of emergency medicines when undertaking home visits. We saw there were two of each emergency medicines which were stored in a secure area. This ensured there was always the required emergency medicines kept in the practice.
- All the medicines and equipment we checked were in date and fit for use.

Are services safe?

- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and was available on the practice intranet and as a paper copy.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results for 2015/16 showed the practice had achieved 87% of the total number of points available, compared to the CCG average of 94% and national average of 95%.

At 4% the overall exception reporting was lower than the CCG average of 9% and national average of 10%. Low exception reporting was reflected for the majority of the domains within QOF. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data showed:

- Performance for some diabetes related indicators was lower than the CCG and national averages. For example, 60% of newly diagnosed diabetic patients had been referred to a structured education programme (CCG 86%, national 92%). However, it was noted the practice had zero exception reporting in this area, compared to the CCG average of 34% and national average of 23%.
- Performance for mental health related indicators was higher than the CCG and national averages. For example, 96% of patients with a complex mental health

disorder had a record of blood pressure in the preceding 12 months, compared to the CCG and national averages of 89%. Again there was zero exception reporting in this area (CCG 10%, national 9%).

We discussed the areas where the QOF figures were lower than the CCG and national averages. The practice informed us how they monitored QOF; they were proactive in inviting patients, chasing up non-attenders and undertaking opportunistic screening. However, due to the period where they had relied on locum nursing staff and practice management, they felt this had impacted on the reviewing of some patients. The locum practice manager and GPs told us about the work they had recently implemented to support improved QOF results and the review of patients. This was evident in the increased figures from the published QOF 2015/16 data, that the practice provided on the day. For example, the number of newly diagnosed diabetic patients they referred to a structured education programme an education programme, had increased from 60% to 87%.

There was evidence of quality improvement arising from clinical audit. There had been several clinical audits undertaken over the previous two years. Some of which were completed, two cycle, audits. Quarterly antibiotic prescribing audits were also undertaken in conjunction with the CCG medicines management team.

We reviewed a two cycle audit, regarding urinary tract infections, which had arisen as a result of changes to guidance in first line treatment. The first audit cycle had showed that out of 20 patients only 10% had been prescribed treatment in line with best practice. A second audit could evidence an improvement in the treatment and that out of 13 patients, 90% had been treated in line with guidance. The remaining 10% of patients had been prescribed an alternative medicine due to repeated infections and already having received first line treatment to no effect.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence we reviewed showed:

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Are services effective?

(for example, treatment is effective)

- Staff had received mandatory training that included safeguarding, infection prevention and control, basic life support and information governance awareness. The practice had an induction programme for newly appointed staff which also covered those topics.
- Staff had access to and made use of e-learning training modules and in-house training. Not all administration staff were up to date with fire safety training, however, they could tell us what they would do in the event of a fire. We were informed that training had been booked for staff to complete by the end of January 2017.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The GPs were up to date with their revalidation and appraisal.

Coordinating patient care and information sharing

The practice had timely access to information needed, such as medical records, investigation and test results, to plan and deliver care and treatment for patients. They could evidence how they followed up patients who had an unplanned hospital admission or had attended accident and emergency (A&E); particularly children or those who were deemed to be vulnerable.

Staff worked with other health and social care services to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. Information was shared between services, with the patient's consent, using a shared care record. We were informed that multidisciplinary meetings and discussions between clinicians in-house took place. However, the practice had lapsed in keeping formal minutes of these meetings. We were assured minutes would be taken from meetings in future. We saw evidence in patients' records that conversations regarding patient care with multidisciplinary staff had taken place, for example with the health visitor or palliative care nurse.

Care plans were in place for those patients who had complex needs, were at a high risk of an unplanned hospital admission or had palliative care needs. These

were reviewed and updated as needed. Information regarding end of life care was shared with out-of-hours services, to minimise any distress to the patient and/or family.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency and Fraser guidelines. These are used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. These included patients:

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- required healthy lifestyle advice, such as dietary, smoking and alcohol cessation
- who acted in the capacity of a carer and may have required additional support

Patients were encouraged to attend national cancer screening programmes, such as bowel, breast and cervical. The practice uptake rate for the cervical screening programme was 70%, compared to the CCG average of 83% and national average of 81%. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. We were informed of some of the difficulties in women attending for screening due, in the main, to their cultural background. The practice had multilingual staff who could explain the screening process. There was access to female smear takers. Patients were contacted and reminders sent to those eligible women.

Are services effective?

(for example, treatment is effective)

Child immunisations were carried out in line with the childhood vaccination programme. Uptake rates were comparable to the national averages. For example, children aged two months to five years ranged from 82% to 84%. We were informed of some of the difficulties the practice had encountered regarding children migrating from other countries and the impact this had on their uptake figures. The practice were continuing to opportunistically promote childhood immunisation.

Patients had access to health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken.

All appropriate new patients aged between 16 and 65, and those who were 'at risk', were screened for latent TB, HIV, Hepatitis B and Hepatitis C. Information was given to support those patients.

Health trainers attended the practice on a weekly basis to provide additional support for patients with lifestyle advice and weight loss. Patients were also signposted to other agencies to support those who were lonely, isolated or depressed.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- Members of staff were courteous and helpful to patients and treated them with dignity and respect.
- There was a private room should patients in the reception area want to discuss sensitive issues or appeared distressed.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place.
- Curtains were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Chaperones were available for those patients who requested one.
- Patients had access to male and female clinicians.

Results from the national GP patient survey showed the percentage of patients' who were happy with how they were treated, was lower than local and national averages. For example:

- 60% said the last GP they saw or spoke to was good at listening to them (CCG 87%, national 89%)
- 64% said the last GP they saw or spoke to was good at giving them enough time (CCG 85%, national 87%)
- 64% said the last GP they spoke to was good at treating them with care and concern (CCG 83%, national 85%)
- 78% said the last nurse they saw or spoke to was good at listening to them (CCG 92%, national 91%)
- 72% said the last nurse they saw or spoke to was good at giving them enough time (CCG 93%, national 92%)
- 75% said the last nurse they spoke to was good at treating them with care and concern (CCG 91%, national 91%)
- 79% said they found the receptionists at the practice helpful (CCG 86%, national 87%)

The results were discussed with the practice, who felt that the lack of a permanent practice manager, practice nurse and GPs contributed to the lower satisfaction rates. They had been heavily reliant on the use of locums over the previous 18 months. In addition, they assured us they were looking at how they could improve patient satisfaction in all areas. However, all of the 17 CQC comment cards we

received were positive about the service and care they experienced. Patients said they felt the practice offered an "excellent and friendly" service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four patients and their views and comments about the practice also aligned with those on the comment cards received. Some of the patients had been members of the patient participation group (PPG) and informed us how the practice had engaged with them. They also expressed an interest in reactivating the PPG. The practice informed us they were intending to reinstate PPG meetings in the very near future.

Speaking with staff, they demonstrated that they were dedicated to improving the quality of care and were positive about any changes which needed to be made to achieve this.

Care planning and involvement in decisions about care and treatment

The practice provided facilities to help patients be involved in decisions about their care:

- The choose and book service was used with all patients as appropriate.
- Longer appointments and additional support were available for those patients who may have had difficulty with understanding their options.
- Interpretation services were available for patients who did not have English as a first language.
- Information leaflets were available in an easy to read format.

The House of Care model was used with patients who had chronic obstructive pulmonary disease (a disease of the lungs), diabetes or were at risk of developing diabetes. This approach enabled patients to have a more active part in determining their own care and support needs in partnership with clinicians. Individualised care plans for these patients were maintained, which included how to manage an exacerbation in symptoms and any anticipatory medication which may be required.

The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.

Are services caring?

Results from the national GP patient survey showed the percentage of patients' satisfaction, regarding their involvement in planning and making decisions about their care and treatment, was lower than local and national averages. For example:

- 62% said the last GP they saw was good at involving them in decisions about their care (CCG 81%, national 82%)
- 72% said the last GP they saw was good at explaining tests and treatments (CCG 85%, national 86%)
- 67% said the last nurse they saw was good at involving them in decisions about their care (CCG 85%, national 85%)
- 88% said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 91%, national 90%)

However, patient comments we received on the day of the inspection were positive regarding their involvement in decision making and choices regarding their care and treatment.

Patient and carer support to cope emotionally with care and treatment

There was a carers' policy and register in place and an alert placed on the patient's record to alert staff. The practice had identified 35 patients who were carers; this equated to less 2% of the patient list. We were informed by the practice that due to their ethnic culture many of their patients did

not see themselves as being a carer. As a result, the practice had a 'whole family' approach to ensure everyone was supported as needed. They were also making a concerted effort to code patients more effectively.

Carers and family members were offered additional support as needed and signposted to local carers' support groups. The practice worked closely with Carers Leeds, which was the main carers' centre for the city. Carers were also encouraged to participate in the Leeds yellow card scheme. The card informs health professionals that the individual is a carer for another person and to take this into consideration if the carer becomes ill, has an accident or is admitted to hospital.

The practice worked jointly with palliative care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. There were currently a small number of patients on the palliative care register and we were informed of the support being provided to those patients and their families.

Patients who had experienced bereavement were contacted by the practice. A home visit was offered by the GP to provide support and advice. Alternatively, they were invited to attend the practice at a flexible time to meet the patient's needs. Certification of death was conducted in line with patients' religious and cultural beliefs.

We saw there were notices and leaflets in the patient waiting area, informing patients how to access a number of support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a good understanding of its patient demographics and provided services to meet the needs of its patients, which included:

- Extended hours appointments until 7.30pm on Mondays.
- Home visits for patients who could not physically access the practice and were in need of medical attention.
- Urgent access appointments for children and those patients who were in need.
- Longer appointments as needed.
- Online services such as booking of appointments and reordering of prescriptions.
- Text messages were sent to remind patients of their appointment.
- Travel vaccinations which were available on the NHS.
- Accessible facilities for wheelchair users and a hearing loop for those patients with a hearing impairment.
- Interpretation and translation services. The majority of the staff were multilingual in languages which befitted their patients, for example Punjabi, Urdu, Mirpuri, Pahari and Polish.
- The choice of a male or female GP.
- A practice information pack was given to all new patients, which included details of the appointment system, complaints process and health advice.

Access to the service

The practice was open between 8.30am to 6pm Monday to Friday. There were extended hours on Mondays from 6pm to 7.45pm. Morning appointments were 9.30am to 12.30pm every weekday. Afternoon sessions were Mondays 4.30pm to 7.30pm, Tuesday 4pm to 5.30pm, Wednesday and Friday 3.40pm to 5.30pm. Although the practice was open to patients on Thursday afternoons there were no clinical sessions in operation. When the practice was closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

The appointment system enabled patients to pre-book up to two weeks in advance, request same day access or an

urgent appointment if needed. We were informed of several examples where the GPs had seen patients outside of the appointment times or 'fitted' someone in as the need arose.

Results from the national GP patient survey showed the percentage of patients' satisfaction with how they could access care and treatment was lower than local and national averages. For example:

- 61% were satisfied with the practice opening hours, compared to the CCG average of 75% and national average of 76%.
- 62% said they could get through easily to the practice by telephone (CCG 68%, national 73%).
- 91% said the last appointment they got was convenient (CCG 94%, national 92%).
- 55% described their experience of making an appointment as good (CCG 69%, national 73%).
- 35% said they don't normally have to wait too long to be seen (CCG 59%, national 58%).

However, patients we spoke with on the day of inspection and comments we received did not align with those results. They told us they were able to get appointments when they needed them and felt confident they would be seen urgently if needed. The practice informed us they were reviewing the appointment system and access in response to the patient survey.

The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. All staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was information available in the practice and in the patient information leaflet to help patients understand the complaints system.
- Complaints were handled by the locum practice manager.

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

We looked at the recorded complaints received in the last 12 months; of which there had been one. This had been a verbal complaint regarding the appointment system. We saw that it had been handled satisfactorily and in a timely way. We saw action and learning had been recorded in that

reception staff had been asked to explain the appointment system to patients as the need arose. We were informed by the practice that they didn't receive many complaints as a routine.

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

Prior to May 2016 there had been three GPs, but the practice was now single handed (Dr Mansoor). We were informed that Dr Mansoor intended to retire and, as part of succession planning, they were in the process of forming a partnership with two local GPs. The two GPs (one male, one female) had recently commenced working some clinical sessions at the practice.

At the time of our inspection we were not provided with a current documented strategy. However, the GPs and locum practice manager could verbally explain what challenges they faced and the actions they intended to take in order to address those concerns. We were informed that a partnership with the two local GPs was in the process of being finalised. This would ensure a stable workforce overall, including a permanent practice manager and practice nurse. (The practice manager and a practice nurse from their practice had been supporting Conway Medical Centre since November 2016.) The partnership would also support continuity of care and a focus on improving the patients' experiences. Once the partnership was finalised a documented strategy would be developed to support the way forward for the practice. We were informed that all staff would be made aware of the future developments, including the vision and strategy, of the practice and supported in managing any changes.

The practice did have a vision to deliver high quality care and promote good outcomes for patients. Staff had reported that the lack of a permanent practice manager, and the impending retirement of the GP, had caused them some uncertainty regarding the future. However, they now felt supported by the locum practice manager and reassured by the planned GP partnership.

There was a strong patient-centred ethos amongst the practice staff and a desire to provide high quality care. This was reflected in their passion and enthusiasm when speaking to them about the practice, patients and delivery of care.

Governance arrangements

We saw that the period where there had been a lack of permanent management staff had impacted on some areas, which was particularly evident in the systems and

processes to support the practice. However, the practice had governance processes in place, which were undergoing review. These were used to support the delivery of good quality care and safety to patients. There was:

- An understanding of staff roles and responsibilities. Staff had lead areas, such as safeguarding, dealing with complaints and significant events, data and recall of patients, and infection prevention and control.
- Practice specific policies, which had been recently reviewed and implemented and were available to all staff.
- An understanding of practice performance. The GPs and locum practice manager we spoke with could verbally inform us of how they were doing compared to other local practices.
- Meetings were held between GPs and staff. Staff could verbally tell us about meetings and how they were made aware of incidents, complaints, safety alerts and practice developments. However, there were no recent minutes of those meetings to support this. We were informed that minutes would be taken in future.
- Clinical audits which had been undertaken and were used to monitor quality and could demonstrate improvements. However, the practice did not have a programme of audits in place, which was shared with other clinicians. We were informed this would be rectified.
- Arrangements for identifying, recording, managing and mitigating risks.
- Business continuity and succession planning in place, for example the partnership with other GPs.

Leadership and culture

We were informed that the practice prioritised safe, quality and compassionate care. Staff particularly welcomed the locum practice manager and felt supported by the systems which had been put in place.

We were informed there was a culture of openness and honesty. The practice was aware of, and had systems in place to ensure compliance with, the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). When there were unexpected or unintended incidents regarding care and treatment, the patients affected were given reasonable support, truthful information and a verbal and written apology.

Are services well-led?

Good 

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

When talking with staff, they could demonstrate a good understanding of the local community and their practice population, in providing services and care in line with their cultural needs.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through day to day engagement with them.
- The NHS Friend and Family Test, complaints and compliments received.

- Staff through meetings, discussions and the appraisal process. Staff told us they would not hesitate to raise any concerns to improve service delivery and outcomes for patients.

Up until approximately 12 months previously, the practice had a patient participation group (PPG). They had met regularly and there was evidence of minutes from those meetings. On the day of inspection we spoke with four ex-members of the PPG, who told us how the practice had engaged with them. They also expressed an interest in reactivating the PPG. The practice informed us they were intending to reinstate PPG meetings in the very near future.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. They had failed to identify the risks associated with:</p> <p>* Nurses not signing patient group directions (PGDs)</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>