

Kirpal Medical Practice

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.

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Summary of findings

Overall summary

Kirpal Medical Practice is based within Soho Medical Centre and provides primary care services for patients in the surrounding area.

All the patients we spoke with were extremely positive about the practice. Patients told us that they were respected and well cared for. Patients felt that if they had a complaint that they would be listened to and their complaint dealt with a timely way.

Appropriate systems were in place to ensure patients were kept safe. The practice provided care in line with current guidance and best practice. The practice worked in partnership with the Clinical Commissioning Group (CCG) and other health teams and was proactive in responding to people's needs.

The leadership style and values at the practice ensured that they were approachable. All the staff we spoke with said the staff team worked very well together. The practice had appropriate governance and risk management measures in place.

We examined patient care across the following population groups: Older people, the practice population aged 75 or over; people with long term conditions, those with ongoing health problems that cannot be cured; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health. We found that care was tailored to ensure that the individual care needs throughout these groups could be met.

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.

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 was safe. The provider had appropriate safeguarding procedures in place. Staff were familiar with the procedures and knew who the safeguarding lead was. Staff were also aware of their local authority policies and procedures for reporting concerns related to the protection of children and vulnerable adults. The practice carried out a criminal record check on all staff before they were allowed to work on their own with patients. Patients were confident that the practice took their safety seriously. We saw evidence that the provider learnt from incidents and medical emergencies. We found that appropriate risk assessments were in place.

Are services effective?

The practice was effective. Care and treatment was being delivered in line with current published best practice. Treatment plans were based on guidance issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were consistently met in a timely manner. The provider had appropriate systems in place to assess the performance of its GPs, nursing, reception and administrative staff. Patients received care that met their individual needs. The practice encouraged patients to be involved with health promotion activities that supported them to maintain their health and wellbeing.

Are services caring?

The practice was caring. Patients were treated with compassion and respect. It was evident at our inspection that the values included in the practice's statement of purpose ensured a patient centred approach to care. We found that these values were readily adopted by staff, emphasised at meetings, discussed within induction and training programmes and included within the policies and procedures used by the practice. All the patients we spoke with and the comments received in our 'Tell us about your care' comment cards were positive and complimentary about the service they received. Bereaved patients were contacted by telephone and encouraged to visit the practice to talk or signposted to appropriate support services based on their wishes.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice was aware of their patients' individual needs. All the patients we spoke with were happy with the access to appointments, obtaining repeat prescriptions and had not experienced delays. Patients told us that

Summary of findings

staff took the time to listen and respond to their questions. There was a clear complaints policy, which was accessible to patients. The practice responded to people's complaints and acted on their suggestions for improving the service. The practice had an active Patient Participation Group (PPG) which was involved with decision making to improve the services provided. The practice participated actively in discussions with the Clinical Commissioning Group (CCG) about how to improve services for patients in the area.

Are services well-led?

The practice was well led. There was a strong leadership and although not a formally written strategy there was a clear vision and purpose. There was a culture of openness throughout the organisation. Governance structures were robust and there were appropriate systems in place for managing risks. This ensured that the practice worked in an open and transparent way based on clear values.

Summary of findings

The six population groups and what we found

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

Older people

The practice assessed and tailored each patient's care to their individual needs and circumstances. Older people we spoke with told us that they had care reviews and received visits at home when needed. Patients care reviews involved their identified carer or a family member if appropriate. Unplanned hospital admissions were reviewed and actions taken when necessary. This involved home visits if required. Older patients had a named GP that they were happy with who was responsible for their care.

People with long-term conditions

There were systems in place for identifying, assessing and managing patients with long-term conditions. The practice supported patients and carers to receive coordinated, multi-disciplinary care and support. Patients with long-term conditions were offered appointments within existing daily clinics. To ensure that they had sufficient time to have a thorough review, patients were given a double appointment slot. The practice specifically reviewed unplanned hospital admissions for this group so that lessons could be learnt. It had particularly targeted the high proportion of diabetic patients in its population group.

Mothers, babies, children and young people

The practice provided a safe environment for mothers, babies, children and young people to receive care. The practice worked well with health visitors located within Soho Health Centre and a local midwifery service to offer care to mothers and babies. Children under the age of five years were provided with a full health surveillance programme. Parents were able to access a GP urgently for serious childhood illnesses. The practice offered or signposted patients to appropriate agencies for sexual health education and contraception advice.

The working-age population and those recently retired

The practice offered extended opening times each evening during the week. This helped to provide easier access for patients who were at work during the day. Patients were offered a choice to accommodate their working times when referred to other services. There was a cervical screening programme in place for women aged 25 years and above. The programme ensured that there was a robust system for following up test results.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

The practice maintained a register of patients with learning disabilities and care plans had been developed with the patient and their carer to support their individual needs. There were no barriers to patients accessing services at the practice. For example people of no fixed address and refugees were enabled to register at the practice and treated appropriately. Patients were encouraged to participate in health promotion activities, such as cancer testing, and smoking cessation.

People experiencing poor mental health

The practice had arrangements in place for assessing and managing individual patients who presented with poor mental health. Annual health checks were offered to people with serious mental illnesses. The GPs had the necessary skills and information to treat or refer patients with poor mental health.

Summary of findings

What people who use the service say

We spoke with 21 patients during our inspection; 19 patients were willing to share their experiences with the expert by experience. We spoke with and received comments from patients who had been with the practice for many years and patients who had recently joined the practice. Patients we spoke with during the inspection were extremely positive about the service they received. They told us that they were respected and well cared for. Patients described the staff and GPs as excellent and told us that they were listened to by all staff.

Patients had completed 30 comment cards before our inspection. All comment cards complimented the service, staff and GPs. Some patients said that they had experienced the problems associated with a busy practice. This included for example getting through reception on the telephone and waiting times at appointments. Some patients told us that they found staff polite and approachable and had not had cause to make a complaint with the way they were treated.

Patients who had cause to make a complaint said that they felt happy that staff had listened and dealt with their concern immediately. Overall patients said that they found the practice helpful and friendly.

We looked at the results of an annual survey for 2013-14 that collected the views of patients who used the practice. The survey was developed by the practice and the members of the patient participation group (PPG). A response was received from 270 patients. This return represented 7% of the patient list. The outcome of patient surveys had identified consistent improvement and positive comments from patients about all aspects of the service provided. Of those patients who responded, 73% were able to make an appointment within their desired timescale and 84% said that they did not have to wait long to be seen by a GP or nurse. People were asked how easy it was to get through to the surgery on the phone 39% said it was very easy, 47% fairly easy, 11% not very easy and 3% had not tried. Since the survey was carried out, the practice had made changes to improve the appointment and telephone system.

Areas for improvement

Action the service **SHOULD** take to improve

The provider should more clearly record the dates when policies and procedures are reviewed and updated.

The practice should ensure that a process is in place to measure the effects of any changes made as a result of clinical audits and therefore complete the audit cycle.

Kirpal Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team included a GP specialist advisor, a second CQC inspector, practice manager specialist advisor and an expert by experience. An expert by experience is someone with experience of using services inspected by the CQC.

Background to Kirpal Medical Practice

Kirpal Medical Practice is based in Soho Health Centre and provides primary care services for people in the surrounding area. The practice is responsible for providing primary care for a registered list of 3,908 patients as of 31 March 2014. The practice is located in an area with a high level of unemployment, social deprivation and a large Asian population.

The practice has two GPs, two practice managers, a practice nurse, a healthcare assistant, two administrators and three receptionists. The practice also utilises the services of health visitors, community midwives and community nurses. The local community health visitor and community nursing teams are based within the building. Out of hours services are provided by another organisation at a nearby location.

The practice provides a range of services including travel vaccinations, child health surveillance and minor surgery, most of which is joint injection therapy.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

The inspection team visited Kirpal Medical Practice at Soho Road Health Centre. This was an announced visit on 11 August 2014. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. During our visit we spoke with 21 patients and six staff. Two of the patients were long term members of the practice Patient Participation Group (PPG). The role of the PPG was to represent patients who used the practice when they wished to raise issues and to comment on the overall quality of the service.

We observed how staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans. We spoke with and interviewed a range of staff including the GP, a practice manager, a practice nurse, reception and administrative staff. We reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. In advance of our inspection we talked to the local Clinical Commissioning Group (CCG) and the NHS England local area team about the practice. We also spoke with patient focus groups where patients and members of the public shared their views and experiences of the service they received from GPs located within the Birmingham and Sandwell areas.

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
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Are services safe?

Our findings

Safe track record

Kirpal Medical practice demonstrated that they had arrangements in place that kept patients safe. We saw that staff had access to policies and procedures which contained clear guidance on the lines of responsibility for reporting incidents of concern. Staff we spoke with were able to describe their role when incidents occurred. All staff were aware of who they should report incidents to. Staff told us that they were encouraged to report incidents.

We were shown records of incidents, complaints and significant events that had occurred at the practice over the last year. Records we looked at showed that monitoring the safety of the practice included the review of information the practice received such as patient safety notifications, medication errors and staff and patient feedback. We read information that showed that safety within the practice was reviewed at regular staff meetings held throughout the year.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events. Minutes we read showed that significant events meetings were held annually. Annual meetings were considered adequate as there had been very few events that had occurred. Records we looked at showed that there had been four significant events between April 2013 and March 2014. Information we read showed that an initial meeting was held to discuss these. This was followed by a thorough review of each significant event. A template completed by staff provided a description of each event, the key risk issues, suggestions to prevent recurrence and the specific action required. The findings were again discussed at clinical and staff meetings. These discussions were recorded in staff records where appropriate and in staff meeting minutes. Staff confirmed such discussions took place. This ensured that there was ongoing learning about where improvement was needed. The practice also notified the local Clinical Commissioning Group (CCG) of these events. The CCG is the NHS body responsible for commissioning local NHS services.

All the significant events recorded for 2013 – 2014 had been non-clinical. For example the practice manager carried out an audit of emergency drugs and found that one was out of date by one month. The practice took appropriate action to prevent this from happening again. The practice manager

had continued to undertake impromptu audits of medicines stored at the practice. There had been one significant event so far since April this year. Information we read showed that this had been investigated appropriately.

Reliable safety systems and processes including safeguarding

We saw that the practice had policies in place for the safeguarding of children and the safeguarding of vulnerable adults. Safeguarding information which included information about the local authority procedures and contact details were clearly displayed in the waiting room. We saw that the practice maintained a register of children who were considered to be at potential risk. We noted that a paper copy marked as confidential was also maintained, however this document was not securely stored. We discussed this with the practice manager and GP who took immediate action to ensure this information was locked away securely and not easily accessible.

The GP was the safeguarding lead for the practice and had completed the appropriate level of safeguarding training. Staff we spoke with were aware of the policies and where to find them. Training records we read showed that staff had completed online training in safeguarding this year at the appropriate levels for their role. Staff were aware of the various types of abuse and responded appropriately to safeguarding scenarios presented to them. Staff told us about the appropriate agencies they would report safeguarding concerns to. A health visitor we spoke with shared an example of a safeguarding concern that was reported to them by one of the receptionists. The health visitor confirmed that appropriate action was always taken by the practice whenever concerns were identified.

We saw there was a chaperone policy in place for patients who required this. There were posters displayed which informed patients of their right to be accompanied by a chaperone. Two of the patients we spoke with confirmed that they had been offered a chaperone when appropriate. Some staff we spoke with demonstrated knowledge of their responsibilities when chaperoning and described what they would do if they had any concerns regarding an examination. Receptionists told us that they were not confident when undertaking the role of a chaperone. To support staff the practice manager told us that training in this area would be reviewed.

The provider had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the

Are services safe?

pre-employment checks to be undertaken before a person could start working at the practice. This included identification, confirmation of qualification through professional bodies, references and a check with the Disclosure and Barring Service (DBS). Staff files we looked at showed that Disclosure and Barring Service (DBS) checks had been completed for all appropriate staff. DBS checks supported the practice to make safe recruitment decisions. This level of scrutiny helped to prevent unsuitable people from working with vulnerable adults and children.

Monitoring safety and responding to risk

Staffing levels were reviewed to ensure that any risks to patients were minimised and their needs safely met. Receptionist and administrative staff told us that they worked as a team and they had all been trained to undertake each other's role. This ensured that at times of planned or unexpected absences the practice continued to operate safely. The practice manager told us that staffing and work planned for the day was discussed at brief meetings held each morning before surgery started.

There were arrangements in place to deal with emergencies. We were shown the emergency medical equipment and medicines kept at the practice. Emergency equipment available included oxygen, a defibrillator and airways of various sizes suitable for adults and children. Staff training records confirmed that staff had been trained to use the equipment. Training completed by staff included basic life support. Staff described to us what care they would provide to a patient in the event of a medical emergency. The GPs and nurses carried bags containing medicines and equipment when making visits to patients in their homes. There was a formal process for checking all the bags and emergency equipment used at the practice.

Medicines management

We saw that medicines were managed, stored and administered safely at the practice. We saw that procedures were in place that provided clear guidance to minimise the risk of errors. The practice nurse and healthcare assistant told us about the procedures they followed to ensure the safe management of medicines. We saw that medicines that were temperature sensitive were stored in a designated medicine fridge. The nurse showed us the records they maintained daily to monitor the temperature of the fridge. The records confirmed that the medicines were stored within the manufacturer's

guidelines which maintained their effectiveness. Staff described to us what they would do if the fridge was not working. This action was confirmed in the business continuity plan we read.

There was evidence to show that staff fully understood the process for storing vaccines, with records that confirmed checks were carried out on a regular basis. For example flu vaccines to be administered to older people were transported in a cold box into the community and appointments were pre-arranged to ensure the effectiveness of the vaccine. We saw that there were signed Patient Group Directives (PGD) in place to support nursing staff in the safe administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a GP. These enabled a nurse to administer a medicine to groups of patients without individual prescriptions.

Systems were in place to ensure that there was a clear audit trail for the authorisation and review of patient repeat prescriptions. Alerts on patient records identified when patients needed to have a health assessment and review of their medicines. Prescription pads were kept safely unsigned and locked away.

Cleanliness and infection control

We saw that systems were in place to protect patients from the risk of infection. At the inspection the practice was visibly clean and organised. Patients told us that the health centre was always clean and fresh and presented as a hygienic environment. Patients told us that staff wore personal protective equipment (PPE) when needed. We observed that personal protective equipment was readily available and used by staff. We saw hand washing posters above each wash hand basin throughout the practice. Leaflets were displayed to advise patients about the importance of hand hygiene.

We spoke with the practice nurse who was the named lead for infection prevention and control at the practice. The nurse had received training to ensure that she was effective in this role. The practice nurse was aware of the Department of Health guidance on the prevention and control of infections and ensured that this was applied at the practice. The practice nurse told us about the systems in place to minimise the risk and spread of infection. The practice nurse told us that she ensured that staff were updated annually, more often if needed on infection control and prevention practices.

Are services safe?

We were shown the surgery's infection control policy. The infection control policy provided staff with clear guidance on the practices they should follow to minimise and protect themselves and patients from the risk of infection.

Information in the policy included the use of personal protective equipment (PPE), washing hands and the safe use and disposal of sharp instruments. Staff we spoke with and our observations of their practice showed that they were aware of the contents of the policy.

Staff we spoke with told us that they had received recent training in infection control, hand washing techniques and the use of protective equipment. A quality improvement audit carried out by the practice infection control lead, listed the essential criteria that staff had to achieve. The outcome of these assessments did not identify any areas of concern. Staff were aware of who the infection control lead was for the practice and knew where to find the policies if they needed to refer to them.

There were procedures in place for the safe disposal of clinical waste and sharp instruments such as needles. Clinical staff we spoke with were aware of these procedures and the arrangements in place with an external company for their safe disposal. The contract for these and the cleaning of the premises was managed by NHS Facilities who owned the building.

Staffing and recruitment

The management team confirmed that they had sufficient numbers of suitably qualified, skilled and experienced staff on duty throughout the week. We saw that there was a weekly staff rota. This was monitored and reviewed to ensure sufficient staff were available to meet the needs of their patients.

We looked at the guidance in place for staff about how to deal with expected and unexpected changing circumstances in respect of staffing. We saw that the business continuity plan and policies on staff sickness, and absences advised staff what to do at these times. We were told by the practice manager, and staff confirmed that administrative and receptionist staff were aware of each other's roles. This ensured that staff were able to stand in for each other in times of absence or busy periods. We saw

that if there was a shortfall in the number of GPs, locum GPs could be used. This ensured that the impact on the practice was minimised and that services to patients continued.

Patients we spoke with told us that they had not experienced any problems with getting an appointment with a GP or practice nurse.

Dealing with Emergencies

The practice had a business continuity and risk analysis plan in place. The document detailed the responsibilities of the management team and identified the action staff should take in the event of a disruption in the running of the service. Information in the plan included instructions on what to do if there was a failure in the supply of domestic utility services, a fire or a change in staffing numbers. The plan contained the emergency contact numbers that would be needed if emergency procedures had to be implemented. This ensured that some or all of the service could be maintained if an emergency or major incident occurred.

Staff working at the practice were aware of the plan, they had access to a copy and were familiar with its contents. Staff we spoke with told us what action they would take in the event of an emergency. Their responses reflected the information in the business continuity plan. Clear and accessible emergency instructions were displayed for staff and patients. Two of the patients we spoke with knew what to do if the fire alarm went off and told us where the assembly point was.

Equipment

The practice was well equipped and had appropriate equipment to support the assessment, diagnosis and treatment of patients in their care. There were policies in place for the safe use and maintenance of equipment. Records we looked at showed that contracts were in place to ensure that equipment used at the practice was regularly calibrated and checked. We saw that equipment such as blood pressure machines and electronic scales had stickers to show that they had been checked. There was also a date to show when they should be tested again. The schedule for maintenance was fully up to date and confirmed that the equipment was safe and suitable to be used.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We saw that the clinical staff had access to recognised best health and treatment advice. We were shown a spreadsheet of National Institute for Health and Care Excellence (NICE) guidance updates. Information showed that they had been read and were used to support the diagnosis and treatment of illnesses. The practice used NICE guidance to ensure the care they provided was based on latest evidence and was of the best possible quality. This ensured that arrangements were in place for the clinical team to manage the care and treatment of the conditions that patients presented at the surgery with. We saw that patients received regular reviews and up to date treatments and tests in line with the guidance available. We saw that the clinicians had the equipment they needed to support their assessments, investigations and diagnosis of the conditions patients presented with.

The practice actively participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF) and local Clinical Commissioning Group (CCG) led enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care in general practice. For example one of the schemes monitored unplanned hospital admissions for all patients. Information we read showed that the practice scored better on prescribing, referring and meeting attendance QOF targets than other practices within the CCG.

The GPs had access to an online prescribing decision support system. The system ensured that the GPs were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments. The GP had done a significant amount of work to reduce the prescribing budget. We saw CCG printouts to confirm this. Information we read related to CCG concerns about the high use of a cholesterol reducing medicine showed that this had been managed using NICE guidelines.

The clinicians we spoke with described the procedures in place to ensure that informed consent was obtained from patients whenever necessary. This could be written or verbal consent. We were told that verbal consent was recorded in patient notes where appropriate. Patients told us that all procedures were explained to them and they

could ask any questions before they consented to any treatment. Patients told us that they did not feel rushed into making decisions about their care and treatment. Patients told us that during consultations they were asked their permission to undertake simple tests such as their blood pressure. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment.

Management, monitoring and improving outcomes for people

The practice had systems in place for completing clinical audits. Examples of clinical audits carried out included prescribing, medicine conversions and joint injections. One of the GPs at the surgery carried out minor surgical procedures in line with their CQC registration and best practice NICE guidance. These procedures mainly involved undertaking joint injections. Clinical staff were appropriately trained to support these procedures. The practice regularly audited the effect of these procedures for patients and used the results to improve learning and outcomes for patients. The practice manager and GP told us about other clinical audits that had taken place. However there was no evidence to confirm that these audits had been repeated to confirm improvement and complete the audit cycle.

The practice had participated in a national initiative to introduce appointments for patients at weekends. The practice manager said that this had been effective especially for working people and to support the reduction of unplanned hospital admissions. Regular review meetings had been held to assess the effectiveness; however we were told that the project ceased due to lack of funding.

We also saw evidence that the practice manager attended peer group meetings with other practice managers to identify and discuss best practice. We saw learning was shared in an appropriate way and recorded in the meeting minutes.

Are services effective?

(for example, treatment is effective)

We saw that the practice maintained registers that identified patients in the different population groups. These were used to monitor and update the progress of patient's wellbeing and ensured that unplanned admissions to hospital were reviewed.

Effective Staffing, equipment and facilities

Staff records we looked at showed that arrangements were in place for staff to receive training to meet the needs of patients. All staff received an induction to the practice. There was a programme for all staff to attend health and safety training. Topics covered included fire safety, infection control, and moving and handling. Staff records and staff we spoke with confirmed that they had regular supervision and annual appraisals. The practice nurse told us that their supervision and appraisal was completed by the GP. Staff told us that their training needs were discussed at this time.

Clinical staff said they were encouraged to maintain and develop their professional qualifications. Clinical staff were provided with opportunities to attend continuing professional development training sessions. A system was in place to ensure that the practice nurses maintained their registration with their professional body. We saw evidence that revalidation was taking place. Revalidation is the process by which all registered doctors have to demonstrate their fitness to practice to the General Medical Council.

There was a process in place for managing poor performance. We saw an example of how this had been implemented. The process had focused on staff learning and improving performance.

Services are provided in a modern purpose-built building. A range of facilities were available to meet the needs of all patients, including patients with a disability. The premises were shared with other NHS organisations; this allowed patients to gain easy access to other health care services. Patients commented that the reception area and treatment rooms were of a high standard.

Working with other services

Our conversations with staff, other professionals and other services and information we read confirmed that the practice had an effective working relationship with other healthcare workers. We found that the practice manager was very enthusiastic and encouraged regular engagement

and meetings with other healthcare workers. We spoke with a health visitor working at the centre who confirmed that the practice actively worked with them and shared information.

The changing needs of patients receiving palliative care were discussed and reviewed at multidisciplinary healthcare meetings. Decisions about their care in relation to resuscitation were sent to the out of hours provider. This ensured that people's wishes about their end of life care could be met.

Systems were in place for managing discharge letters, information from the out of hours service and the receipt of blood results. All letters and results were first passed to the GPs to review when they were received. The administration staff recorded a summary of this information on patients' records. Patients received clear instructions on the action they should take to obtain test results. We saw details of these instructions in the practice leaflet and the practice website. If there were concerns about a patient's test results the patient was contacted by the GP.

The noticeboard in the waiting area provided patients with information about local health and social care services. The information provided included details of the different support and wellbeing groups patients could access. For example we saw leaflets and notices about different carers, mental health and mother and baby groups. The practice website was linked to NHS Choices. This signposted patients to local care services that could meet their needs. The practice leaflet also gave patients information about other healthcare services that they could access.

Health, promotion and prevention

There were systems in place to identify the varying levels of healthcare needs within the population served by the practice. The promotion of healthcare and the prevention of ill-health started at the registration stage of new patients. New patients were asked to complete a questionnaire about their health, family history, and social habits. They had an initial examination and health assessment completed by the GP or practice nurse.

We found that in the waiting area there was extensive healthcare education information and details about external organisations that offered healthy living advice. Elderly patients we spoke with told us that they had joined local walking groups. Whilst this helped to keep them healthy and active it also provided an opportunity to

Are services effective?

(for example, treatment is effective)

socialise. Leaflets available included health information on smoking cessation, diabetes, nutrition and the importance of exercise. Although most of the information in the waiting area was in English the practice told us that they could get the information in different languages if needed. The practice also accessed an online translation website that translated information about a patient's condition into their language. This supported patients to read about their illness and treatment choices in a language they understood. Patients told us that they found the information in the waiting room useful and did read the leaflets and notices.

The practice held childhood immunisation and baby clinics. The uptake of childhood immunisations was monitored by the practice. If there were concerns about a child's health the practice referred them to the health visiting team.

The CCG had concerns that the practice was not meeting targets in respect of smoking cessation. The CCG is the NHS body responsible for commissioning local NHS services. To address this the practice introduced smoking cessation posters and questionnaires in all consulting rooms. Patients were advised about the risks of smoking during consultations and referred to appropriate smoking cessation clinics for help.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 270 patients undertaken by the practice and the members of their patient participation group (PPG). The outcome of these surveys identified improvements and positive comments from patients about the services provided. For example the national patient survey showed that the GP was much better than expected at involving patients in decisions about their care.

We spoke with 21 patients who all spoke positively about the service they received at Kirpal Medical Practice. Patients told us that they were treated with dignity and shown respect by all members of staff. We observed staff speaking to patients in a polite and respectful manner both in person and on the phone. We observed that the reception area was an open area. To overcome this we noted that staff were discreet when speaking with patients and ensured that they could not be overheard. Patients told us that they were listened to by the clinicians. Patients said that their care and treatment was planned and discussed with them and any questions they had were answered.

We saw that patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. We saw that the doors to consulting rooms were closed and that staff knew to knock and wait for a response before they entered. Patients told us that these practices happened at all times.

There were arrangements in place to support patients following bereavement. The staff at the practice told us that bereaved patients were encouraged to visit them at the practice to discuss and talk about their loss. The staff

ensured that patients were aware of the supporting agencies available to them. Leaflets with contact information and details about the support the agencies offered were available for patients in the waiting area.

There were arrangements in place to offer care and support to identified carers of patients. Services offered included health checks and access to counselling support if needed.

The practice was located in a modern building designed to ensure that appropriate care and treatment was provided to patients with a disability. We saw that the entrance to the practice was designed so that patients with mobility difficulties could access the practice easily. There was accessible parking and step free access to the doors. The consultation rooms were situated on the ground floor and the waiting area, corridors and consultation rooms were spacious allowing patients easy access.

Involvement in decisions and consent

We found that patients were involved in decisions about their care. The practice served a diverse population. To support meeting their needs the practice ensured that access to information about the services they provided was available in different languages. People told us that they received clear information either in writing or verbally from the GP and the nurse in an appropriate language that they could understand. Information we received from patients in comment cards told us that the clinicians explained things in a way that they could understand.

Information in staff files and training records showed that all staff had received training in the Mental Capacity Act 2005. Staff demonstrated an in depth knowledge of the implications of the act. The patients that lacked capacity had access to advocacy services with the involvement of their carer or next of kin as appropriate. This ensured that the right people were involved in decisions about their relatives care. There were also alerts on the computer system so that staff knew which patients were supported by carers.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

We found that the practice was knowledgeable about the population it served. The services provided were planned to meet the care needs of its local population. The practice demonstrated that they were aware of the health conditions and risks the different population groups presented with. The largest group of patients on the practice patient list were Asian. The Asian population can be at a higher risk of developing diabetes. We were shown measures the practice had taken to target patients with diabetes, particularly those who seemed to have difficulty in managing their own condition. Information we read showed that patients were offered additional support and education to help them understand and manage their illness.

We looked at the arrangements in place to meet patients' equality and diversity needs. The staff at the practice were mainly of Asian descent. Staff spoke the languages and were familiar with the varied dialects spoken by the majority of their patients. We saw that health information leaflets were mainly available in English. Staff told us that patient health information could easily be accessed in different languages. They said they used an online translation website to translate information on conditions patients presented with and treatment they might need into a language that met their individual needs. The practice also had access to a language interpretation services by the telephone or an interpreter could visit the practice if booked in advance.

Patients were given written instructions on when and who to contact at the practice to get the results of any tests carried out at the practice. The practice contacted patients directly or asked them to visit the practice if they had concerns about a patient's test results.

The practice involved their patient participation group (PPG) in discussions about changes that affected patients. This included the introduction of new patient leaflets.

Access to the service

The practice offered patient appointments between the hours of 9.30am and 12.30pm and from 3.30pm to 6pm.

The practice was closed on Wednesday afternoons. Outside of these times and at weekends an out of hours service was provided by another provider. All calls were diverted to the NHS 111 service.

The results of a recent survey undertaken by the practice identified that patients were relatively happy with the appointment system. Results showed that 73% of the respondents were able to make an appointment within their desired timescale and 84% said that they did not have to wait long to be seen by a GP or nurse. There was varied response when patients were asked how easy it was to get through to the surgery on the telephone 39% said it was very easy, 47% fairly easy, 11% not very easy and 3% had not tried. Following the survey the practice had made and continued to make changes to improve the appointment and telephone system.

Patients told us that they had had no problems obtaining repeat prescriptions. Patients were aware of the systems in place at the practice for ordering their prescriptions. Patients told us that they requested their prescription 48 hours in advance either in person or by leaving their request in the prescription request box at reception. Their prescription was always ready for collection when they returned 48 hours later.

Meeting people's needs

The practice had a written cultural and religious policy that covered the different cultural and religious needs of patients. The policy ensured that staff were aware of the varied religious and cultural beliefs of patients that could impact on how their healthcare needs were met. Topics covered included the views of religious groups on blood transfusions, family planning, terminations, fasting and dying and death. Specific instructions related to an individual patient's care and their cultural or religious beliefs were marked on their files to alert staff to their care and treatment preferences.

One of the GPs told us that they ensured that patients understood the choices they had available to them. Patients requiring specialist investigation or treatment were referred using the 'choose and book' system. People told us that the choice of care and treatment available was explained to them and additional information was given in writing to help them make their decision. Patients that had been referred for specialist treatment told us that they were happy they had made the right choice.

Are services responsive to people's needs?

(for example, to feedback?)

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The policy identified clear lines of accountability for handling complaints. Information was also included on the handling of verbal complaints. Reception staff told us that they would deal with complaints at the time they received them. All complaints were reported to the practice manager. The practice manager was the designated responsible person who handled all complaints received by the practice.

Patients had access to the complaints procedure on the noticeboard in the waiting room. Details on how to make a complaint was also published on the practice web site and in the practice leaflet. Patients we spoke with told us that they had not had cause to complain about the services they received. Patients knew how to make a complaint if they needed to and believed that the practice would take their complaints seriously.

We looked at the complaints received this year. We saw that they had been investigated and responded to in a timely manner. Any learning from complaints received was shared with staff and appropriate improvements were made.

Are services well-led?

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

Our findings

Leadership and culture

The practice had a written document that detailed its aim to promote quality care for patients. These aims were shared with members of the patient participation group (PPG), in patient leaflets and in the practices' statement of purpose. Staff were also made aware of these aims through staff meetings. This was confirmed in the minutes of staff meetings. Staff told us that there was a spirit of openness and they were encouraged to share their views and be involved in how the practice operated and developed. We saw that there was a positive working relationship between all staff both clinical and nonclinical. Staff could clearly describe their role in areas of responsibility and accountability. Staff knew who they were immediately accountable to. Staff told us that the management team were easily accessible and approachable.

The practice did not have a written long-term plan. They preferred to discuss plans for the practice informally and as positive decisions were made about changes they shared this with staff and patients where appropriate. The long-term plans discussed included collaboration with practices within the centre, the implementation of a computerised patient information system and the recruitment of a female GP.

The practice manager and the GP (who was also the registered manager) were in day to day control of the service. The practice manager was involved in all aspects of the work at the practice. All the staff we spoke with said that both the practice manager and GP were supportive and approachable.

The staff performance monitoring system was used both to recognise and reward staff performance and to identify any potential underperformance. There was a low turnover of staff. Information in staff records showed that most of the staff had worked at the practice for a number of years. Staff told us that they enjoyed working at the practice and felt valued both individually and as a team.

Governance arrangements

We saw that there was a clearly identified staff and management structure with clear lines of staff accountability and reporting. As part of its governance arrangements the practice had clearly identified lead roles. These roles included designated leads for safeguarding,

infection-control, medicines management, and complaints management. Staff told us that they took these responsibilities seriously and were aware of the importance of their roles. The management team regularly reported to the local Clinical Commissioning Group (CCG) that the service was operating safely and effectively.

We saw that staff had access to policies and procedures which contained clear guidance on their lines of responsibility. We noted that the policies and procedures used by the practice were not dated to clearly show when they had been reviewed and updated.

Systems to monitor and improve quality and improvement

The practice had systems in place to assess and monitor the quality of service that patients received. We saw that the provider carried out a number of audits designed to assess the quality of its services.

Monitoring was carried out as part of the CCG agreed quality indicators and Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice reported their performance against identified indicators to the CCG monthly. The practice was able to see if their performance was below that expected so that actions could be put in place for improvement.

The provider met with other local practices to share best practice and experiences. Where appropriate experiences shared could be used to improve services for patients.

Patient experience and involvement

The practice asked patients who used the service for their views on their care and treatment. Patients were encouraged to provide feedback about the practice and the care they received through surveys and a comments box in the reception area. We saw that the practice analysed the results of the survey and any issues identified were acted on and discussed with patients at PPG meetings and with practice staff at staff meetings. We saw records of these discussions within the minutes of staff and PPG meetings. Patient surveys were completed every year. The results of these were also published on the practice website. All the patients we spoke with on the day of our inspection told us they received a quality service that met their needs.

Are services well-led?

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

Practice seeks and acts on feedback from users, public and staff

The practice had an established Patient Participation Group (PPG). At this practice the group was referred to at times as a Patient Reference Group. The group was used as a focus group to review changes in the practice and new patient information. A PPG is an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care provided. We spoke with two members of the PPG who told us that the group was proactive in helping to make changes for the benefit of patients who used the practice. The practice manager told us that they worked closely with the PPG and involved them in the way the services were delivered.

The staff we spoke with told us that they felt able to express their views to the practice manager and that any suggestions they had for improving the practice would be taken seriously.

Management lead through learning and improvement

The practice demonstrated that they were a learning organisation. All staff had an appraisal completed annually. These provided staff with performance goals and identified their training needs. Staff were encouraged to maintain their professional qualifications and take up further training to meet the needs of the service.

Identification and management of risk

The practice had an effective system in place to identify, assess and manage risks to the health, safety and welfare of staff and patients. We found that service wide risk assessments had been completed. These included safety checks of the building, fire safety, electrical faults and the safe disposal of sharp instruments and clinical waste. Audits were evaluated and an action plan put in place to improve services where needed.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

We saw that older patients were treated with sensitivity and empathy when they visited the practice. Staff offered support to older patients with their mobility and movement around the practice if needed.

Planned and unplanned hospital admissions were reviewed and patients followed up on discharge. Older patients told us that they were visited at home following discharge from hospital. The provider regularly reviewed the care provided to older people and included their family members and carers in decisions about their treatment when appropriate.

All patients over the age of 75 had a named accountable GP and a named care co-ordinator. Older patients including those nearing the end of their life had care plans in place. Care plans were developed with the patient and their identified carer. This also involved other health and social care agencies as appropriate. Multidisciplinary meetings were held to review and update patients individual care needs. Patients were also given a copy of their care plan. The telephone number and contact details of housebound older patients' was shared with the out of hours and ambulance services, where appropriate and only if consent had been obtained.

The practice offered flu and shingles vaccinations to older patients who were most at risk.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice supported and regularly reviewed patients with long term health conditions such as asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease and diabetes.

The practice ensured that there was a recall protocol in place for patients who required chronic disease management. Patients that were housebound had an annual review of their health carried out by the practice nurse and healthcare assistant in their homes.

Patients were encouraged to be involved in managing their illness and received health information and advice to support them to do this. The practice involved other health professionals and made referrals to specialist services for further assessments or treatment.

Multidisciplinary meetings that included community nurses and Macmillan nurses were held. This ensured that patients care, treatment and progress was reviewed and changes made as appropriate.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

There were effective safeguarding procedures in place to help protect vulnerable children. A register was maintained of children assessed as being at risk. Staff had an understanding of obtaining consent for children and young people. Procedures were in place that allowed children and young people to have their preferences considered.

The practice worked well with health visitors to offer a full health surveillance programme for children under the age of five years. Immunisations clinics were offered to children and the uptake of vaccinations was monitored. Parents were given priority to see a GP urgently when children had serious illnesses.

The practice held postnatal and baby follow up clinics six to eight weeks after delivery.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered evening appointments four days per week. Patients of working age people were able to book appointments in advance. Patients were able to book telephone appointments if they wanted to speak to a GP without having to attend the practice.

Men and women over the age of 40 years were offered health checks every three years. The screening offered included breast examination, cytology and prostate assessments.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The provider enabled people of no fixed address and people with refugee status to register at the practice. This meant those patients were able to access all NHS services.

Patients with learning disabilities had individual care plans and were given a full health check annually or sooner if required. There were alerts on the records of patients known to be at risk of substance misuse.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

For patients with mental health problems, the practice worked closely with professional organisations and signposted patients to local support agencies where appropriate. This included the community psychiatric

nursing team to help ensure that people received the mental healthcare and support specific to their needs. The practice Patients experiencing poor mental health had a full health check annually or sooner if required. Patients had access to a psychologist and medication reviews were completed.