Dr Arshad Khan

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Arshad Khan (Central Medical Centre) on 15 January 2015. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and respected them
- The practice had a well-established and well trained team with expertise and experience in a wide range of health conditions

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

The provider should:

- Ensure minutes of meetings consistently record decisions taken and identify staff responsible for completing actions.
- The practice should ensure evidence of identity is held for all staff employed.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and any safety issues addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Over the last two years, the practice has improved its performance when compared with others within the Coventry and Rugby Clinical Commissioning Group (CCG). Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals and was a member of the local Godiva Prescribing Quality Programme. As a result the practice had been able to reduce prescribing of certain medicines in line with medical guidelines more effectively. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group

Summary of findings

(CCG) to secure service improvements where these were identified. Although previous survey results indicated below average performance in terms of patient experience and access, we saw that the practice had taken action to address these areas. Patients we spoke with during our inspection reported good access to the practice and said that urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

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

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and where appropriate, were included on the practice's avoiding unplanned hospital admissions list to alert the team to patients who may be more vulnerable. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. At the time of our inspection, the practice had just completed delivering its flu vaccination programme. The practice nurse had arranged to do these at patients' homes if their health prevented them from attending the clinics at the surgery.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma, diabetes and Chronic Obstructive Pulmonary Disease (COPD), a lung condition. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Members of the GP and nursing team at the practice ran these clinics. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. The practice had a high percentage of patients (10%) with diabetes. As a result, the practice employed a specialist diabetes nurse, who was also a prescriber for one day every week. In 2014, a pilot scheme was organised which saw diabetic patients have clinics at the practice with a diabetic consultant from George Eliot Hospital, Nuneaton to identify and improve outcomes for patients.The practice has developed a partnership with an independent health provider to and review patients with? asthma and Chronic Obstructive Pulmonary Disease (COPD), a lung condition.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics. There was a weekly antenatal clinic. At the time of our visit, the practice did not run a dedicated baby clinic, but we were shown plans to launch one during spring 2015. GPs told us however, how babies and children were given priority in the appointment system and this was supported by comments made by patients. Child flu

Summary of findings

vaccinations were also provided. A midwife came to the practice twice weekly to see expectant mothers. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered a family planning service.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours until 6.30pm four days each week for patients unable to visit the practice during the day. The practice also had arrangements for patients to have telephone consultations with a GP. The practice was proactive in working to offer online services and at the time of our visit was developing a new website to facilitate this. Health promotion included smoking cessation and healthy eating advice.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. The practice monitors patients with learning disabilities (LD). All patients with learning disabilities were invited to attend for an annual health check. The practice regularly worked with multi-disciplinary teams with vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. The practice works in partnership with the local Community Mental Health Team to identify patients' needs and to provide patients with counselling, support and information. Patients were referred to a memory clinic when this was felt to be appropriate.

Summary of findings

What people who use the service say

Results from the GP national patient survey were below average nationally and for the Coventry and Rugby Clinical Commissioning Group (CCG). A total of 43.3% of patients surveyed found it easy to get through to the practice on the telephone, 46% of patients would recommend the practice to friends and family and 53% of patients said the last time they saw a GP, they felt they had been given enough time.

However, most patients we spoke with told us the availability of appointments was good, although one patient told us it was difficult to get through on the telephone at times. GPs and patients told us that if an appointment was needed in an emergency and all the appointment slots were full, additional appointments were made on the same day to ensure all patients who required an urgent appointment were seen.

We gathered the views of patients from the practice by looking at 30 CQC comment cards patients had completed and by speaking in person with ten patients. Some patients who gave us their views had been patients at the practice for many years. Patients were largely positive above the practice and commented on how professional, friendly and helpful staff and GPs were.

After our inspection, we spoke by telephone with a patient who was involved with the Patient Participation Group (PPG). The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patient views were included in the design and delivery of the service.

Patients told us they were treated with dignity and respect and the GPs, nurses and other staff provided good care. Patients we spoke with expressed appreciation for the service they had received and some had recommended the practice to friends and family members.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure minutes of meetings consistently reflect who attended meetings, decisions taken and identify staff responsible for completing actions.
- The practice should ensure evidence of identity is held for all staff employed.

Dr Arshad Khan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Dr Arshad Khan

Dr Arshad Khan (Central Medical Centre) is situated approximately a mile to the north of Coventry city centre. The practice has been in existence for over thirty years. It has 3,520 patients.

The practice is in an area with a high ethnic population and 70% of patients do not speak English as their first language. Patients' health needs reflect the ethnic community. There is a high rate of diabetes, over twice the national average (10% of patients) and a high rate of coronary heart disease. The practice has a higher than average proportion of patients with long term medical conditions and who are smokers. The practice is located within a designated deprived area and income deprived families are more than double the national average. There is a high rate of unemployment. The practice has one of the most deprived patient lists within the Coventry and Rugby Clinical Commissioning Group (CCG). The level of deprivation is 30% above the CCG average.

The practice provides a range of NHS services including an antenatal clinic, family planning service and smoking cessation support. The practice also undertakes minor surgical procedures. The community midwife visits the practice twice weekly.

The practice has one male GP, a locum female GP (employed by the practice), a practice nurse and an assistant practice nurse. Chaperones are used for patients who request the service, which is advertised throughout the practice. Working alongside the clinical team is a practice manager, and administrative and reception staff.

The practice has a Primary Medical Services (PMS) contract with NHS England. A PMS contract is a contract between general practices and NHS England for delivering primary care services to local communities.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we gathered before the inspection we had no specific concerns about the practice. Data we reviewed showed that the practice was achieving results that were average or slightly below average in some areas with the England or Clinical Commissioning Group. Results from the GP national patient survey were below average nationally and for the Coventry and Rugby Clinical Commissioning Group (CCG), for example 46.1% of patients would recommend the practice to friends and family.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services which they can access by using the NHS 111 phone number.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Coventry and Rugby Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced visit on 15 January 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with ten patients who used the service, and contacted a further patient, a member of the Patient Participation Group (PPG) after our visit.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

During our inspection of Dr Arshad Khan, we reviewed how the practice identified risks and carried out actions to improve patient safety. We reviewed documentation for the last two years, this included six safety incidents. Documents included safety records, reports of incidents and the minutes of meetings when such matters had been discussed within the practice.

The practice used various methods to enable staff to identify risks and take appropriate action to improve patient safety when needed. This included processes for reporting incidents and disseminating information contained within national patient safety alerts to all relevant staff. It was evident the practice also assessed information gathered from clinical audits and health and safety audits it had carried out, with patient safety as a priority.

The practice also reviewed safety following comments and complaints they received from patients and staff. For example, we were shown how the practice improved procedures for document control and storage after a patient's record was lost.

Records we examined demonstrated the practice had effectively managed safety incidents and had evidence of a safe track record over a longer timescale.

Learning and improvement from safety incidents

Appropriate systems had been implemented by the practice to report, record and monitor all significant events. This included incidents and accidents. We looked at any significant events that had occurred within the last two years. We found incident records had been correctly completed within an appropriate time and when patients had been affected by a necessary change or something that had gone wrong, in line with practice policy, they were given an explanation and if necessary, an apology and informed of the actions taken.

We reviewed one incident when an incorrect medication had been issued to a patient. The practice quickly corrected the error and ensured there had been no health risks to the patient. At the same time, the practice reviewed the records of other patients who had been prescribed the same medication. This and all other recorded incidents and significant events were discussed at practice meetings. This included reviewing progress made on actions that had arisen from previous incidents.

During our inspection, we saw the practice had learned from the incidents and significant events that had occurred. Findings and conclusions had been shared with relevant staff and all staff we spoke with, both clinical and non-clinical, knew the reporting procedure.

We also saw the practice discussed national patient safety alerts in staff meetings, along with any action to take as a result of each safety alert. At the time of our inspection, a national patient safety alert had been issued regarding recognising the early stage symptoms of Ebola and we saw evidence this had been discussed with staff.

Reliable safety systems and processes including safeguarding

Dr Arshad Khan had appropriate procedures in place to ensure any risks to vulnerable children, young people and adults were identified and any action required was carried out in a timely way. All staff we spoke with fully aware of these procedures and knew what they should do when a situation occurred. They had a knowledge of who the incident should be reported to within the practice, of the documentation that needed to be completed and of the relevant agencies that needed to be contacted, both within working hours and out of office hours. We saw relevant contact details were clearly available and these were regularly reviewed to ensure they were correct. The GP discussed the system used to highlight vulnerable patients on the practice's patient records.

All staff we spoke with knew how to recognise signs of potential abuse in older people, adults and children. We also asked staff about the training they had received. When we reviewed the training records held by the practice, we found all staff had received appropriate training in safeguarding that was specific to their individual role within the practice. The role specific training included the practice GP who was safeguarding lead. The practice could demonstrate they had the necessary training to enable them to carry out this role and showed us relevant training certificates.

Good

Are services safe?

The practice was also able to us they had a good working relationship with relevant safeguarding partner agencies, such as the Warwickshire County Council's Social Services department. We saw all safeguarding concerns had been discussed a monthly multi-disciplinary team meeting.

There was a chaperone policy in place for patients and staff. 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. Notices about this were clearly displayed for patients to see within the waiting room and in consulting rooms. All nursing staff had been fully trained to act as chaperones and those we spoke with correctly described their responsibility. The practice had completed chaperone audits in 2012 and 2014 and was due to repeat the exercise later in June 2015. This was to ensure chaperones were provided when requested, that staff training remained up to date and the duties had been carried out correctly to patients' satisfaction. Results from the audits carried out in 2012 and 2014 demonstrated the practice had met the requirements.

Medicines management

We saw that all medicines stored within the treatment rooms and medicine refrigerators were correctly and securely stored. This included ensuring medicines were stored at the correct temperature. Procedures were in place to govern this and the medicines refrigerator had its temperature checked and recorded on a daily basis in line with this procedure. Guidelines were also in place to detail action to be taken if a power failure occurred. There were also procedures in place to ensure medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice did not hold stocks of controlled drugs. Medicines were only accessible to appropriate staff and we saw training records to confirm staff had received appropriate medicines management training when necessary.

Vaccines were administered in accordance with directions that had been produced in line with legal requirements and national guidance. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. No stocks of controlled drugs were held.

During our inspection, we saw records of practice meetings that noted the actions taken in response to a review of prescribing data. The practice is part of the Godiva Prescribing Quality Programme, in which practices work together to reduce prescribing levels of certain medicines, e.g. blood thinning medicines. As a result the practice had been able to reduce prescribing of certain medicines in line with medical guidelines more effectively. It is currently at position 26 the Coventry and Rugby CCG prescribing indicators dashboard out of 79 practices within the CCG, an improved position from where it was two years ago.

The GP told us how all prescriptions were reviewed and signed by the GP before they were given to the patient. Blank prescription forms were stored in line with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice had appropriate infection control procedures in place. This included the infection control policy and supporting policies for areas such as the safe use and disposal of sharps; use of personal protective equipment (PPE); management of spills of blood and bodily fluid. This enabled staff to plan and implement measures for infection control within the practice and effectively assess risks to patients and staff. To enable this to be carried out, a practice nurse had been appointed as the lead for infection control. They had received relevant training for this role which enabled them to provide advice on infection control measures within the practice and provide training to staff. We looked at training records. They demonstrated all staff had received role specific induction training about infection control, followed by ongoing training and updates when required.

We looked at the infection control audit that had been carried out by the infection control lead in January 2015. This had also been undertaken annually in previous years. Any improvements identified for action had been completed on time. Following the latest audit, the decision had been taken to remove children's toys from the waiting room due to the increased risk of infection during the flu season. Minutes of practice meetings showed the findings of the audits were discussed.

Arrangements were in place to ensure the safe disposal of clinical waste and sharps, for example, needles and blades. We saw evidence that their disposal was arranged through an appropriate company.

Good

Are services safe?

During our inspection we noted the premises were visibly clean and tidy. Cleaning schedules were in place and cleaning records were kept. The practice employed its own cleaner. Patients we spoke with told us they always found the practice to be clean and tidy. We saw notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were also available in treatment rooms.

There was a policy in place for the management, testing and investigation of legionella, this is a germ found in the environment which can contaminate water systems in buildings. We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

We observed that staff had relevant equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff we spoke with explained all equipment was tested and maintained regularly. We also saw equipment maintenance logs and records to confirm this. Portable electrical equipment was regularly tested. A testing schedule was in place and appliances displayed stickers indicating the last testing date, April 2014.

Staffing & Recruitment

The practice had appropriate measures in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff on duty. A weekly staff rota was compiled several weeks in advance. This took account of any additional staffing requirements that might be needed, for example, immediately following a bank holiday or when staff were on annual leave. There was always a member of clinical staff on duty when the practice was open. Most administrative staff were also part time; this ensured staff cover was available if a team member was unexpectedly absent. We looked at procedures in place at the practice for staffing. This included sickness and disciplinary processes.

Practice staffing was also reviewed to take into account the needs of the local population and ensure sufficient staff were available to meet demand. Staff we spoke with confirmed this was the case and most patients we spoke with told us they could usually get an appointment when they needed one.

Management told us that in the event of a shortage of GPs, a locum GP could be used, although this had not been necessary so far. However, a female locum GP was permanently directly employed by the practice to provide female GP cover. A shortage of GPs was also one of the risks covered by the practice business continuity plan. This would help to ensure sufficient GPs were available to continue to meet the needs of the practice patients.

The practice had a suitable recruitment policy in place. This gave details of the pre-employment checks the practice had to carry out on a successful applicant before that person could start work in the practice. They included checks on identification, references and a criminal record check with the Disclosure and Barring Service (DBS). All staff, including administrative staff, were DBS checked.

During our inspection we looked at a selection of staff files for a GP, administrative staff and nurses. The records we viewed demonstrated the recruitment procedure had been followed. However, one of the staff files did not contain evidence of identity as required under current legislation. We were told by management and administrative staff that the practice had a consistent and long serving staff team and did not often need to recruit.

Monitoring safety and responding to risk

The practice carried out regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. These were part of the procedures the practice had put in place under its health and safety policy to ensure all risks to patients and staff were identified and effectively monitored.

Each risk was assessed, recorded in a risk log and rated with appropriate actions recorded to reduce and manage each risk. We saw that identified risks were discussed during staff meetings. We also saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

We saw appropriate information about health and safety was clearly displayed for all staff to see and the practice manager was the designated health and safety representative and had received training for this additional duty.

Arrangements to deal with emergencies and major incidents

Dr Arshad Khan had appropriate arrangements in place to manage emergencies. For example, we saw records held by the practice that showed all staff had received training in

Good

Are services safe?

basic life support. There was emergency equipment was available within the practice. This included oxygen and an automated external defibrillator, which was used to attempt to restart a person's heart in an emergency. Staff we spoke with knew where this equipment was kept, records indicated it was checked regularly and we saw records to confirm staff had been trained to use it.

There were emergency medicines kept in a secure area of the practice. Staff knew the location. We saw medicines which included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). The practice had processes in place to check whether emergency medicines were within their expiry date and therefore suitable for use. We checked the dates on a selection of the medicines and found they were in date and fit for use.

The practice had a business continuity plan in place which was regularly reviewed in the light of any changing circumstances. This dealt with emergencies that could impact on the daily running of the practice, for example power failure, adverse weather, including flooding, unplanned sickness and access to the building. An annual fire risk assessment had also been carried out. This included actions required to maintain fire safety. If the practice building was unavailable, we saw arrangements were in place for the use of alternative local premises, a community centre.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We saw the practice had appropriate systems in place to assess the needs of patients and then deliver care and treatment in line with medical guidelines and the wishes of the individual patient. Guidance issued by the National Institute for Health and Care Excellence (NICE) were used by clinical staff during the diagnosis and treatment of patient's medical conditions. This ensured patients received care based on the latest medical evidence and up to date tests and treatments.

Patients we spoke with and patients who completed comment cards were satisfied with the care they received from Dr Arshad Khan. This included any follow up treatment needed after their initial appointment. Patients told us GPs were professional and sympathetic. We were also told that practice staff provided excellent care.

We were shown how the practice had identified and discussed concerns that arose from an increase in the prescribing of a particular sleeping tablet. The prescribing of this medicine was in line with other practices in the area. The GP attended a workshop organised and hosted by another local practice in April 2014 and has since recorded a 27% reduction in the usage of this medication since April 2014. The practice is now below the average for prescribing it within the Coventry and Rugby Clinical Commissioning Group (CCG) and within England.

Clinical staff managed the care and treatment received by patients with long term conditions. Appropriate systems were in place to ensure such patients were reviewed at least annually. Conditions included diabetes, asthma and hypertension (high blood pressure). Out of the patient list of 3,520 patients, the most vulnerable 2% had care plans in place in line with NHS guidelines. The lead GP explained how the practice liaised with care homes and carers if patients were admitted to care homes or needed domiciliary care put in place to enable them to continue to live in their own homes. Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed.

Management, monitoring and improving outcomes for people

The practice used completed clinical audit cycles to monitor its performance with patients and identify areas that needed to be improved. The practice had set dates to repeat these audits to ensure improvements were continuously being made. Some of this assessment was undertaken for the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward doctors for implementing good practice. We saw evidence the practice had improved its performance in recent years. For example, at the time of our inspection, it had achieved a total of 94.3% of the total available points under QOF. In 2011-2012, the practice had scored 82.4%.

Examples of completed clinical audits included minor surgery and patients who required chaperones. This had been undertaken in 2012 and 2014 and was due to be completed again in June 2015. This was carried out in the context of the lead GP being male and the practice had a large number of female patient appointments, not all of which could be covered by the appointment times available with the female locum GP. This was to ensure chaperones were provided when requested, that there was no reduction in chaperone usage, that staff training remained up to date and the duties had been carried out correctly to patients' satisfaction. The practice is currently at position 26 the Coventry and Rugby Clinical Commissioning Group (CCG) prescribing indicators dashboard out of 79 practices within the CCG, an improved position from where it was two years ago.

The practice had developed a partnership with an independent health provider to examine and review patients with asthma and Chronic Obstructive Pulmonary Disease (COPD), a lung condition. This had resulted in additional patients being called to the practice for review when they had been identified as moderate or severe.

We were satisfied the practice identified and took appropriate action when areas of concern were identified. For example, the higher than average number of patients who were prescribed sleeping tablets. The practice worked with other neighbouring local practices to identify and reduce this, an example of how the practice worked with other practices to share training and best practice. As a result, the practice had seen a significant reduction in the prescribing of these medicines. The specific needs of the local population were also identified as there was a high

Good

Are services effective?

(for example, treatment is effective)

rate of cardiovascular disease, hypertension and strokes, usually found in an area with a high ethnic population group. The practice had carried out work to identify and treat patients with such conditions at an early stage. It was planned to undertake clinical audits of this later in 2015 to determine the benefit to patients.

Effective staffing

The practice staff included medical, nursing, managerial and administrative teams. During our inspection we looked at a range of staff training records. It was clear staff were up to date with training, for example, in basic life support and safeguarding. We saw GPs were up to date with their yearly continuing professional development requirements. All GPs had either been revalidated or had a date for revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). Staff also had annual appraisals. These were used to identify training needs and action plans were formed. Staff we spoke with confirmed the practice provided training and funding for relevant courses. Training was prioritised.

Nursing and staff had detailed job descriptions and the practice was able to demonstrate they were trained to carry out these duties. For example, administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked closely with other services to ensure patients' needs were met and more complex medical needs were effectively managed. This included the receipt of blood test results, X-rays results and information from the local hospital and out-of-hours GP services, for example discharge summaries and records of treatment. Identifiable staff read and acted on this information when it was received. Staff concerned understood their roles.

Records confirmed the practice worked closely with the community midwife service, health visitors, community mental health professionals and community drug teams. Patients were referred to local clinics for blood testing, chiropody and anti-coagulant (blood thinning) testing.

There were integrated team meetings held every one or two months to discuss concerns. This included the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. We saw minutes of these meetings and evidence that clinical updates, significant events and emergency admissions to hospital were discussed and actions identified. We saw that some meetings had missing information about which staff members attended the meetings, decisions taken and which staff members would be responsible for any actions.

The waiting room contained a large selection of leaflets about locally available services. Most of these were available in the other languages represented within the local community. Relevant information was also displayed on a large screen computer monitor within the patient waiting room, this was also multi-lingual.

Information sharing

Practice staff used an electronic patient record to document and manage patient' care. The package enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. All staff were fully trained on this.

The practice used recognised electronic systems to share communications with other organisations. As an example, there was a shared system with the local GP out-of-hours provider. This ensured patient data was shared in a secure and timely way. The practice received details of all out-of-hours attendances before 8am on the next working day in line with national guidance. A system was also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Consent to care and treatment

The practice had a process to ask for, record and review consent decisions that were needed from patients. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. Some patients we spoke with confirmed this.

Processes included one to obtain signed consent forms for children who received immunisations. Information was also available about of potential side effects of

Good

Are services effective?

(for example, treatment is effective)

immunisations. The practice nurse recognised the need to obtain consent from parents and what to do if consent was needed when a parent wasn't available. The GP and nurses we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with showed they had an understanding of the Mental Capacity Act 2005 and appropriate knowledge about best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

When patients needed an interpreter, practice staff were usually able to interpret as most staff were multi-lingual. When this wasn't possible, the practice could use an interpretation service.

Health Promotion & Prevention

The practice offered NHS health checks to all its patients aged between 40 and 75 years. Since April 2014, the practice had offered 164 NHS health checks and 88 patients had accepted. This was slightly below the average for the Coventry and Rugby Clinical Commissioning Group (CCG) area. The practice followed up those who failed to respond. The practice's performance for cervical smear uptake was above average compared to others in the CCG.

When patients registered with the practice for the first time, they were offered an appointment with a practice nurse. If the practice nurse identified any medical concerns, the patient was referred to the GP or another healthcare professional if more appropriate.

We were shown work the practice had carried out to identify and promote particular health needs within the local community. For example, with the high local level of diabetes and coronary heart disease. These rates were in line with those expected within the particular ethnic community and with the high level of deprivation locally. Patients who smoked were referred to the smoking cessation support provided by University Hospital in Coventry.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with and patients who completed comment cards, were happy with the care they received and any follow-up needed once they obtained an appointment. Patients felt they were consistently treated with dignity and respect by all members of staff. Most of the patients we spoke with also commented on how friendly and helpful all staff and GPs were. None of them made negative comments. The GPs were also described as sympathetic by patients. During our inspection we saw how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients. We saw evidence that all staff had received customer service training in response to previous feedback from patients.

We were told by the GP how patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

The national patient survey carried out in 2014 had results that were below average for the Coventry and Rugby Clinical Commissioning Group (CCG). For example, 53% of respondents said the last GP they saw or spoke to was good at giving them enough time. The CCG average was 86%. A total of 52% of respondents described their overall experience of this surgery as good, against a CCG average of 83%.

In December 2014, 85 patients completed a patient survey, issued by the practice. This was the first patient survey ever carried out by the practice and represented 2.5% of the patient list. Of those patients who responded, 80% felt they were treated with respect by staff; 51% were happy with the treatment proposed by the GP; 53% were happy with the GP's decision making and 49% were happy with the availability of practice nurse appointments. These figures were also below average for the CCG.

An action plan was put in place following these survey results. Longer appointments have been offered for patients with chronic health conditions, additional practice nurse appointments have been made available and the practice has increased the promotion of on-line services, such as appointment booking. Later in 2015, management intended to review progress made with resolving these concerns.

Care planning and involvement in decisions about care and treatment

During our inspection, we saw patients were given appropriate support and information so they could make informed decisions about their care and treatment needs. Staff told us how this was discussed with patients before any treatment started and how they assessed what care and support each patient needed. When we spoke with the GP, it was explained how they discussed any proposed changes to treatment or medication with each patient at the time a proposed change was identified. The GP explained how they kept patients fully informed during consultations and treated patients with consideration and respect.

Patients told us they felt listened to by their GP and the practice staff. Some patients indicated that they had long term health conditions and said that they were seen regularly.

Patient/carer support to cope emotionally with care and treatment

We did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provide for carers and links to refer patients to appropriate organisations, including a counselling service for professional support, this included family members after bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Dr Arshad Khan had appropriate systems in place to monitor and maintain its service level. The practice responded to the needs of its patients and kept this under review. GPs and staff understood the needs of the practice population and systems were in place to address any identified needs in the way services were delivered. GPs provided examples of how the practice responded to the needs of the local community. For example, following an emphasis on identifying patients with dementia, we were shown how the practice had increased dementia screening and ensured 'at risk' patients were identified on their patient records. The practice is involved with the National Enhanced Service Dementia Identification Scheme which has improved the practices' identification of patients with early stage dementia.

The needs of patients with long term conditions were kept under review. In 2014, a pilot scheme was organised which saw some diabetic patients have clinics at the practice with a diabetes consultant from George Eliot Hospital, Nuneaton to identify and improve outcomes for patients. The practice had registers of patients with mental health support and care needs and with learning disabilities. Each patient on the registers was invited for an annual review. Staff told us they had a good working relationship with the local community mental health team.

We looked at minutes of meetings that discussed patient capacity and demand. As a result, changes were made to staffing and clinic times when required. Following the national and local patient survey results in December 2014, the number of practice nurse appointments had been increased to meet an increase in demand. Services were also reviewed in the wider context of the local health community. Review meetings were held with the Clinical Commissioning Group (CCG) and a GP attended these.

The practice had an established Patient Participation Group (PPG). The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with promoting the recent patient survey and the formation of the practice action plan which followed it.

Tackling inequity and promoting equality

Of the patients who used Central Medical Centre, 70% spoke English as their secondary language. All GPs and administrative staff were multi-lingual, so could easily have a conversation with patients. We saw that information leaflets were available in a variety of languages in the waiting room, as was the information displayed on the visual display unit in the waiting area.

There was an induction loop to help patients who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required.

Access to the service

The practice opened from 8am to 6.30pm every weekday, except on Thursdays when it closed at 1.30pm. Cover was provided by the out of hours service during this time and was accessible by patients telephoning the NHS 111 service. GPs and patients told us that if an appointment was needed in an emergency and all the appointment slots were full, additional appointments were made on the same day to ensure all patients who required an urgent appointment were seen. Telephone consultations were also available. Following the national and local patient survey results in December 2014, the number of practice nurse appointments had been increased to meet an increase in demand. Outside of these times and during the weekend, an out of hours service was provided by another organisation and patients were advised to call the NHS 111 service. This ensured patients had access to medical advice outside of the practice's opening hours. Additionally, the practice was within walking distance of a frequent direct bus journey to the local walk in centre.

Appointments could be booked for the same day, for within two weeks' time or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice.

The information from CQC comment cards and patients we spoke with indicated that the service was easily accessible and that patients were always able to get an appointment on the same day they phoned if this was needed. Following the 2014 national patient survey results which showed

Good

Are services responsive to people's needs?

(for example, to feedback?)

43.3% of patients found it easy to get through to the practice on the telephone, the practice made changes to its telephone system and in conjunction with the PPG, improved and put an increased emphasis into its on-line services.

Listening and learning from concerns & complaints

The practice received and acted upon concerns and complaints from patients. This was in line with guidelines and contractual obligations issued for all GPs in England. The practice manager handled all complaints in the practice. The complaints procedure was clearly displayed within the waiting room, along with clear information on how a patient could make a complaint if they wished to do so. This was also printed within the patient information pack. All the patients we spoke with said they had never had to raise a formal complaint. It was clear that verbal complaints were dealt with in the same way as written ones. The practice manager told us, if a patient telephoned the practice to complain, they would immediately take the call if available and attempt to resolve the concerns immediately if possible. The practice compiled a complaints summary which summarised the complaints for each year which was used to identify any trends.

During our inspection, we looked to see whether the practice adhered to its complaints policy. Three complaints had been received within the last 12 months. None related to safety incidents and there were no re-occurring themes. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. One complaint related to a perceived delay with a repeat prescription. Following this, the practice clarified its procedure requiring 48 hours' notice for a repeat prescription and made an improvement to its website to make this clearer when repeat prescriptions were ordered on-line.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice aimed to provide 'a friendly and caring service'. We saw this was referred to on the practice website and in the patient information leaflet produced by the practice. Staff we spoke with mentioned it during our discussions with them. During these discussions it became highly evident that staff intended to give patients a safe, caring service where patients were treated with dignity and respect. Staff understood the values held by the practice and put them into practice as they carried out their daily roles.

The GP partners held quarterly partners' meetings outside of surgery opening times. We looked at minutes of some of these meetings and saw they discussed topics such as forward planning, practice objectives, future direction and vision. The practice regularly reviewed its objectives during staff meetings. The lead GP told us the practice aimed to provide a high standard of evidence based medical care.

GPs and management demonstrated how they wanted to be involved with clinical initiatives and had pursued opportunities when time and resources allowed. For example, the practice is involved with the National Enhanced Service Dementia Identification Scheme which has improved the practices' identification of patients with early stage dementia.

Governance Arrangements

The practice used information from a variety of sources to help them assess and monitor their performance. This included information from their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group. QOF is an annual incentive programme designed to reward doctors for implementing good practice. The practice had improved their performance within the Coventry and Rugby Clinical Commissioning Group (CCG) for the Quality and Outcomes Framework (QOF). As a result its performance was now above average for the CCG, having been below average two years ago.

The lead GP had lead roles with specific areas of interest and expertise. This included governance with a clearly defined lead management role and responsibility. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities. The practice held a regular meeting of clinical staff, this included discussions about any significant event analyses (SEAs) that had been completed. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues.

Leadership, openness and transparency

Dr Arshad Khan was a sole lead GP who had previously worked as part of a partnership. Some of the staff team had worked together over a number of years. They were supported by a practice manager who staff described as being very approachable. The staff we spoke with told us the practice was a good place to work where they were supported and valued by management.

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

The practice had a Patient Participation Group (PPG). This met every three months. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patients' views were included in the design and delivery of the service. We saw minutes of previous PPG meetings and saw how the PPG has been fully involved in initiatives such as the first patient survey which had been carried out in December 2014 and in the formation of the action plan which followed this survey and the national patient survey carried out during the same year.

All the patients we spoke with on the day of our inspection told us they were happy with the service they received from the practice. The practice had closely monitored patient comments and had action plans in place following the patient surveys carried out in 2014. For example, the practice had provided customer care training for all staff and the number of appointments available with the practice nurses has also been increased as a result of comments from patients. We saw that the practice had plans in place to repeat the patient survey later in 2015 and in future years and make appropriate changes to the action plan as improvements were identified or other areas of patient concern were raised. All staff were fully involved in the running of the practice. We saw there were documented staff meetings every two months.

Are services well-led?

Good

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

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. For example, within the last 12 months, safeguarding and customer service training had been carried out. Clinical staff had protected learning time for training, which had included disease management for older people, prescribing management and gynaecology. Best practice was discussed and shared with colleagues from other practices.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.