King Cross 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.

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at King Cross Practice on 14 April 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people and the working age population.

Our key findings across all the population group areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints would be addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles. The practice carried out regular appraisals and put in place personal development plans for staff.

Are services caring?

Good

The practice is rated as good for caring. Patient surveys showed that the practice compared favourably with other practices in the area. Patients said 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 also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and that there was continuity of care, with urgent appointments available on the same day. The practice had adequate facilities and was well equipped to treat patients and meet their needs. The practice had an effective complaints system.

Summary of findings

Are services well-led?

The practice is rated as good for well-led. The leadership team were effective and had a clear vision and purpose. There were systems in place to drive continuous improvement. Governance structures were in place and there was a robust system that ensured risks to patients were minimised.

Good 

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia care. The practice was responsive to the needs of older people and where appropriate provided home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. Patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and those who were at risk. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people including those recently retired and students. The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a record of patients living in circumstances that may make them vulnerable including homeless people, travellers and those with a learning disability. The practice offered longer appointments for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health including people with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had advance care planning in place for patients with dementia.

Summary of findings

What people who use the service say

We received 29 CQC comment cards and spoke with patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

The patients were complimentary about the care provided by the staff, their overall friendliness and behaviour of all staff. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and that they were given a professional and efficient service. They told us that long term health conditions were monitored and they felt supported.

Patients reported that they felt that all the staff treated them with dignity and respect and told us the staff listened to them and were well informed.

Patients said the practice was very supportive and felt their views were valued by staff. They were complimentary about the appointments system and its ease of access and the flexibility provided.

Patients told us that the practice was always clean and tidy.

King Cross Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector, a CQC Senior Project Manager and two specialist advisors (a GP and a practice manager).

Background to King Cross Practice

King Cross Practice is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in Halifax. The practice has four GPs (two male and two female), a management team, practice nurses and healthcare assistants, administrative staff and cleaning staff.

The practice is open from 8am to 6pm Monday to Friday. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nursing clinics. When the practice is closed patients accessed the out of hours NHS 111 service.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The practice is part of NHS Calderdale CCG. It is responsible for providing primary care services to 7465 patients. In common with other neighbouring practices in the CCG Calderdale area the proportion patients who are over 65 is high.

Why we carried out this inspection

The King Cross Practice was part of a random sample of practices selected in the Calderdale CCG area as part of our new comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

We carried out an announced 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 in accordance with the Care Act 2014.

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?

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
- Mothers, babies, children and young people

Detailed findings

- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews and via comment cards completed by patients of the practice in the two weeks prior to the inspection visit. We spoke with GPs, the practice manager, clinical nurses, health care practitioners, administrative staff, the data quality manager and service advisors.

We observed how staff treated patients when visiting and telephoning the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We saw that there was an incident reporting policy and paper forms. The practice was involved with the circulation of incidents/lessons learnt that would be implemented across all practices in the clinical commissioning group (CCG). The practice also held an incident log, conducted significant event audits (SEA) annually plus various ad-hoc investigations and lessons learnt procedures.

The SEA we were shown included a record of those patients who had been referred to secondary care with suspected cancer and did not attend their appointment (DNAs) and we were shown a sample of the electronic records which acted as a failsafe backup with pathology to ensure that patients attended follow up appointments.

We were told there was an open culture of reporting incidents and highlighting concerns.

Staff who identified an incident could talk to the practice manager or a GP and there was a reporting form to record this information. Incidents were prioritised so that urgent action could be taken if required, they were also discussed at a monthly meeting where minutes were kept and actions managed. We saw there was an issues log kept for matters such as delayed discharge summaries and these were relayed via the clinical commissioning group (CCG) monthly meeting.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us.

A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every week to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding.

We asked members of the medical, nursing and administrative staff about their most recent training. A GP had attended level three safeguarding training which was renewed in the last 3 months; the practice nurse had level three; we noted they followed the local child protection protocols. There was a monthly meeting that considered safeguarding incidents with local social services teams.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had named GP's and nurses appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

Medicines management

Medicines were prescribed by the GP and other authorised clinicians following guidelines in British National Formulary (BNF) and local guidelines. The practice was fully engaged with Calderdale CCG and its initiatives to promote safe, evidence based, cost effective prescribing. We saw a copy of the 'Medicines Management Protocol' and a medication audit which had been carried out in November 2014. We saw the date for review of the audit was scheduled for May 2015.

Patients or their representatives could order repeat medication at reception, via email or via a nominated pharmacist. Repeat medication meant that medication which was on the patients repeat list and was not underused or overused.

Good

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

The practice had a repeat medication protocol and all staff involved with prescribing were aware of this.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and protocols for the decontamination of surfaces and the environment in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean.

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and annual updates thereafter. We saw evidence the lead nurse had carried out audits for the last year and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. We saw a copy of an infection control audit dated November 2014.

Hand hygiene techniques guidance was displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

Regular waste collections took place. There were sharps bins in each clinical room. Specimens were sent off each day, labelled and placed in sealed, hygienic packaging with appropriate request forms secured within. These were checked by service advisors prior to sealing in colour-appropriate bags for transport to the lab.

A Hepatitis B Register was kept by the practice nurse. This was an effective system to ensure all clinical staff were vaccinated. Clinical Staff records were checked on recruitment.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example ear syringe machine and the vaccine fridge thermometers.

All staff including clinicians underwent basic life support (BLS) / cardio pulmonary resuscitation (CPR) and emergency equipment training annually and three yearly respectively. The practices nurse lead also updated staff and familiarised everyone with the emergency equipment and checked this periodically.

All electrical equipment was tested annually. We saw stickers on all the equipment that showed a testing expiry date.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS).

Staff recruitment was conducted through internal and external advertising and all recruitment was subject to appropriate levels of DBS clearance and satisfactory references. All new members of staff were employed on a three month probation period. New contracts had been drawn up recently for all staff and the practice have an updated staff handbook.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Safe procedures were in place to ensure that criminal record checks via the disclosure and barring service (DBS) were undertaken where necessary. Risk assessments of all

Good

Are services safe?

roles and responsibilities had been completed to determine the need for a criminal record check. Criminal record checks of staff employed within the practice, were repeated at three year intervals.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. We saw a copy of the most recent risk register which highlighted 20 risks which included flu pandemic, telephone failure and safeguarding.

Arrangements to deal with emergencies and major incidents

In-hours winter pressures sessions had been run last winter to help cope with increased demand on services during the season. This had also helped to reduce pressure on A&E and non-core primary care services across the community.

All staff were trained in cardiopulmonary resuscitation (CPR). A member of the clinical team was on-site during the majority of the opening hours.

Service advisors operated the reception desk and were vigilant to the well-being of patients in the waiting area. Clinicians also visually reviewed those waiting when they called in their next patient.

Alarm systems both within the IT system and a push button which alerted staff in the building to assist in emergencies.

Flu Saturdays were held to target those at risk. This provided access to those patients who worked as well as those who were elderly who had long term conditions (LTC)s.

The business continuity plan was reviewed on an annual basis. The practice has a reciprocal arrangement with two other practices whereby premises would be made available should these be required and the practices electronic patient records would be accessible from these remote locations.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patient's needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with the GP who told us they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, referral to other services and management of long term conditions or chronic conditions such as hypertension.

E-mail alerts were received from NICE by both the practice manager and lead nurse. Updates and recommendations were incorporated into the practices guidance and protocols. These were shared with appropriate clinicians and staff in a timely manner. This included at clinical meetings, on practice documents and via notifications. Also hard copies were circulated and signed by each relevant person to confirm they had read and understood the guidance.

Where an alert related to a drug, reports were run from the clinical system and actions taken to ensure patient safety was maintained.

The practice has a holistic, patient-centred approach to patient assessment, care planning and delivery. Individual needs of the patient were discussed in every consultation. The use of templates and 'auto-consultations' covered a wide range of clinical contacts which ensured consistent assessment, record keeping and coding.

Referrals to hospitals or other services had set criteria (choose and book) which clinicians followed. 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. Clinicians worked with conditions set by the practice.

Records were coded to highlight war veterans who received priority when referring for an armed service related illness. Records were also coded to highlight patients who had physical disabilities or impairments so that care could be tailored accordingly.

The practice operated a call and recall system for patients with long term conditions (LTC) or chronic conditions that ensured safe management of these.

Quality Outcomes Framework (QOF) attainment was good which reflected good care and outcomes for the patients. This was constantly reviewed. Individual clinicians were responsible for allocated clinical areas to monitor progress and outcomes and took early remedial action if any problems areas were identified.

The bi-monthly MCM (Multi-disciplinary Care Meeting) reviewed the palliative care register with community and Macmillan nurses. Minutes of these meetings were documented in the meeting book.

The practice maintained a 'poorly patient' list which was reviewed on a bi-monthly basis and was available to all staff to ensure that these most vulnerable patients received timely clinical assessment even when the patient themselves may not deem it was needed.

Deaths were also reviewed at this meeting in order to share experiences and any lessons learnt.

The risk stratification database was updated on a quarterly basis. This identified patients who were at a greater risk of unplanned hospital admission. The GPs reviewed this to determine which patients were suitable to be added to the care register. Through an agreed comprehensive care plan, this helped the practice deliver proactive care to try and reduce the risk and support these patients to maintain their independence.

Discrimination of all types was avoided when making care and treatment decisions. Clinicians were trained in equality & diversity awareness. Following attendance at a recent practice managers meeting, the practice was in the process of developing an updated equality & diversity policy.

The practice compared favourably with other similar services in respect of patient outcomes and this had been fairly consistent over time. The NHS England primary care web tool allowed the practice to view other practices' performance, for example dementia diagnosis rates. This tool was used by the clinical commissioning group (CCG) to benchmark practices and inform developments through commissioning engagement.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses

Good

Are services effective?

(for example, treatment is effective)

showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Clinical audits were carried out involving all relevant staff. The results of these audits were analysed and the actions/ improvements were discussed at the monthly clinical meetings. Any changes to policies or protocols were made where necessary.

In the last 12 months the practice has undertaken a programme of audits including prescribing, infection control standards, cancer referrals and medicines management.

Action plans were developed and any changes to policies made to ensure robust arrangements were in place. These action plans were discussed at relevant meetings.

Clinical staff undertook a programme of training to ensure they were suitably qualified for the roles they performed. Continuing professional development ensured clinicians kept up to date with any changes which could be implemented in each practice and shared amongst colleagues at monthly clinical meetings.

Mandatory training programmes were also vital to ensure robust clinical governance. These include CPR/Life support, anaphylaxis, safeguarding vulnerable adults and children and infection control.

The practice had an open culture of reporting significant events, these could range from issues treating a patient to issues concerning buildings and maintenance. Each significant event was logged, investigated and lessons learnt disseminated across the practice. The central electronic incident reporting system had recently been put in place.

Maintenance and regular review of risk registers ensured that identified risks were managed appropriately, taking actions to reduce the impact and likelihood to its lowest level. This was a relatively new addition to the governance arrangements in the practice.

The practice manager and lead nurse received clinical alerts and action them accordingly, maintaining a record of the action taken. These could relate to medicines, equipment, staff or patients.

The practice had recently worked collaboratively with four other practices in the locality to case find patients either at risk of developing type II diabetes or who were previously undiagnosed diabetics. The result of this work was shared with all practices in Calderdale in March 2015. Patients identified as being at risk of developing type II diabetes had been put on a 'recall for repeat bloods' in the last 12 months. Appropriate management of those diagnosed with type II diabetes commenced accordingly.

The practice fully participated in the CCG's Commissioning engagement scheme for 2014/15 which focused on quality indicators covering a number of areas. As part of this work, practices compared their outcomes with peers. A best practice protocol for managing patients with type II diabetes was shared as well as a clinical review protocol.

For outcomes following referrals, electronic and paper correspondence were scanned onto the patient's record in a timely manner so that the clinicians were aware of the diagnosis and onward management of the patient's condition. Recalls were added where appropriate and medication linked to each problem heading.

Effective staffing

All GPs were up to date with their yearly continuing professional development requirements and all either have 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 had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. Staff we spoke with told us that newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and we saw that this covered areas such as safeguarding vulnerable adults and children, health and safety, fire and first aid.

Staff told us that they felt they had opportunities to develop and were able to take study leave and protected time to attend courses. Multi-disciplinary training and the

Good

Are services effective?

(for example, treatment is effective)

open supportive culture were evident at this practice. The practice held a protected learning session dedicated to domestic violence in the last month and this was an area they felt should be updated for staff.

Staff recruitment interviews were always held by two senior staff/ clinicians. All staff received annual appraisals where personal development plans (PDP) were agreed and an evaluation of each persons performance was made. The practice had looked at the structure of the organisation they provide and with the help of an outside consultancy made robust changes to the structure to offer a better service. This has involved a lot of consultation with staff and patients through the patient reference group (PRG).

The practice had recruited three new members of staff in the last 12 months and this included a practice manager, practice nurse and service advisor team leader. Pre-employment checks were carried out as well as interviews.

Statutory & mandatory training was organised within the practice. The practice had protected learning time provided by the CCG which enabled the practice to close one afternoon per month. These dates were clearly advertised to patients in advance both in the practice and on the website.

Open discussions were held with staff should any performance issues arise. Staff members were supported through such periods in order to improve their performance.

Working with colleagues and other services

The practice had clear arrangements in place for referrals to other services. Patients told us that they were given a choice of which hospital they would like to be referred to. It was the GPs responsibility to follow up on the referrals.

The practice maintained good relations with community services including, community matrons, district nurses and health visitors who attended the monthly clinical meeting held at the practice. At these meetings specific patients of concern were discussed to ensure all clinicians were aware of clinical/social issues. New guidance was disseminated and specific clinical issues were raised. For example, if a GP or nurse had attended an educational session and needed to update the clinical team.

When referrals were made by clinicians to other services, the secretaries were alerted through tasks to ensure these were facilitated in a timely manner. They proactively managed the referrals on a daily basis.

Any patient contact with NHS 111 or GP Out of Hours services was either documented directly onto the patient's record or the electronic information was received and processed by the practice.

The nursing team was alerted, by the summarisers (staff that input this data onto the IT system) to any patients who were over 75 or were on the unplanned admissions register who had been discharged from hospital. These patients were contacted within three working days of receiving the notification to ensure effective care was in place.

Information sharing

The practice manager told us that they had a commitment to the nine care homes which it managed from a medical viewpoint. GPs visited as and when required. There were structured templates for each of the patients and the information was also cascaded to the out of hours provider who could usually see the practices IT system notes but who also received faxed copies of special notes for each of these patients where appropriate. This demonstrated a good level of communications with other providers.

The practice held a central repository of policies, protocols and referral forms in additional to on-line formularies and information websites, like 'NaThNaC' and the 'Green Book'. All staff had access to the central repository called 'Practice Documents'. There was also the Choose & Book appointment system for referrals.

The electronic patient record within the IT system held comprehensive information relating to the patient's care including any care plans, test results and risk assessments. All staff within the practice documented and coded, where appropriate, any interactions with patients

Any paper communications were scanned onto the system. Electronic letters were allocated to the relevant clinician for review and action.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing where possible. These care plans were reviewed annually or more frequently if changes in clinical circumstances required it. While talking with staff they gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of Gillick competencies. These were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The appropriate codes were included in either auto-consultations or templates so that the patient's record captured this assessment.

Health promotion and prevention

The practice conducted NHS Health Checks on patients aged 40-74 to assess their risk of developing Cardiovascular disease (CVD) in the next 10 years. Any patients found to be at risk (score of >10%) was given lifestyle advice as well as the option for taking statin medications.

Following a recent case finding audit, patients who had pre-diabetic HbA1C results (43-47) had been highlighted as 'at risk of diabetes'. A recall was added to have the blood test repeated in 12 months' time. Patients had also been seen and given healthy lifestyle advice.

Eligible patients were invited and encouraged to have immunisations against flu, shingles, and pneumonia plus childhood diseases as part of the national programmes.

Reminders were sent where patients did not make an appointment. For childhood immunisations, any DNAs were recorded and followed up on a monthly basis by the nursing team in addition to the quarterly return.

One staff member administered the cervical screening service. They ensured that patients were recalled for follow up as necessary. They worked closely with the nursing team to co-ordinate this.

During any consultation with a patient, healthy lifestyles was discussed. This could include smoking, substance misuse (including alcohol) or healthy weight. Patients could self-refer to support services when making healthy lifestyle changes.

Patients with long-term conditions were encouraged to attend their review appointments where healthy lifestyle was discussed if appropriate. Self-management of their condition was encouraged, where possible.

Patients in the last 12 months of their lives were discussed at the multi-disciplinary clinical meeting to ensure they were fully supported by all professionals involved in their care.

Patients who were identified as carers were supported and signposted to appropriate resources.

All patients with long term conditions, a learning disability or over 75 were invited to an annual health/chronic disease review. Where possible synchronising reviews for those with multiple conditions so that one holistic review was carried out and this improved patient experiences.

GPs were proactive in supporting patients who had significant work absence to try to minimise time lost from work due to illness/injury.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient survey tool and feedback from patients undertaken by the practice via the patient reference group. We saw the 'Patient Satisfaction Survey – Report and Section Plan' for 2014 and 2013. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the GP patient survey showed that 96% of patients who responded said that their last appointment was convenient for them. The practice was also above average 100% for its satisfaction scores on 'had confidence and trust in the last GP they saw or spoke to'.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 29 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was evidence of learning taking place as staff meeting minutes showed issues had been discussed.

The practice prides itself on the care it delivered to patients. Staff were sensitive to the needs of patients and took into account their varying needs. The practice was planning to hold an 'Equality and Diversity' workshop in a future protected learning time to reinforce this message.

The comments received through friends and family test (FFT) demonstrated that patients felt that they were treated with dignity and respect by staff.

The 'Raising Concerns Whistle Blowing Policy' in place supported staff in raising concerns if they were aware of when attitudes were disrespectful, discriminatory or abusive.

The use of chaperones in the practice was advertised on the website, in the waiting room and in the practice leaflet. Patients could use this service at any time. Each examination couch had a modesty sheet and where necessary a paper curtain could be used if a patient needed to undress.

All staff were aware of the implications of confidentiality breaches and respect patient confidentiality at all times. Although the reception area was fairly open, patients had an opportunity to request holding private conversations in a side room.

The use of smartcards was in place to access patient records electronically. These were never left unattended in areas where patients could have access and PCs were locked when not in use.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the GP patient survey showed 97% of practice respondents said 'the last GP they saw or spoke to was good at explaining tests and treatments' and 97% felt the 'the last GP they saw or spoke to was good at giving them enough time'. Both these results were average in comparison to this CCG area and the national averages.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and

Good

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the CQC comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

The practice treated patients holistically therefore patients were at the centre of their care "no decision about me, without me". The central repository held various patient leaflets that were given to patients about their care, treatment or condition to help them make informed choices.

The practice had assigned patient status markers for patients who had a physical disability or impairment (wheelchair user, hearing impaired and visually impaired). They had coded records to highlight war veterans who received priority when referring for an armed service related illnesses.

The practice was starting to build up their website to help patients with long term conditions (LTC) manage their condition using other resources. So far they have a link to Diabetes UK on it and they plan to do more on this in the future.

Patients who had complex needs were reviewed frequently with a care plan in place where necessary. Those patients who had been identified as being at risk of unplanned admissions to hospital were reviewed at least every three months, sooner if they had been to A&E or admitted. All elements of care plans were agreed with the patient or carer and the clinician.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

When patients were experiencing particularly emotional periods in their lives, be it due to their physical or mental health or circumstances, the practice prided itself on being compassionate. Having been established nearly 30 years, the GPs had supported families for a generation.

All the GPs had good relationships with their patients, which was demonstrated by the high number of gifts the practice received at Christmas and at other times of the year. They also had a "Thank You and Celebrations" board where cards and compliments were displayed.

When patients needed support that went beyond general practice, they were signposted to a number of services who could help them including Macmillan and bereavement support. There were also a number of voluntary sector organisations that patients could be signposted to for support including 'Age Concern'. This support was also available for carers and dependents.

'Gateway to Care' was a single point of access for patient with health and social care needs. Patients were signposted or could self-refer.

Wherever possible, the practice supported patients to manage their own health and maintain independence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

There had been very little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local nursing and residential care homes by a named GP. The result of this was seen in the reduced need for unplanned call-outs and reductions in unplanned admissions to hospital. The practice had achieved and implemented the gold standard framework for end of life care.

The practice collected data on appointment usage on a weekly basis which was used to inform future planning of services. GPs worked nine sessions each week which resulted in half day working one day a week. In acknowledgement of Monday being the busiest day, GPs took their half day Tuesday to Friday. This maximised the number of appointments available at the busiest times.

The additional demand on the service during the winter period meant that additional capacity was needed. Commissioners were acutely aware of this and provided resources to enable practices to increase capacity during this time. For 2014/15, an additional session was added each Monday with a further session at the end of the week added when GPs were on leave. These additional 14/28 appointments a week had been fully booked throughout the period.

At the start of "flu season" the practice held a Saturday clinic (Flu Saturday) where over 600 eligible patients were vaccinated. For 2015/16 they were planning two Flu Saturdays to increase flexibility and availability. To effectively manage the clinics they were held a couple of weeks apart. This would also ensure that the nasal flu vaccine had been delivered to the practice.

The practice was open from 8am until 6pm Monday to Friday offering appointments that were bookable in advance (28, seven and two days before) and on the day for urgent needs. Where possible patients were triaged to the telephone list for a call-back. The practice also offered a range of GP appointments for patients to book online up to four weeks in advance at varying times with all GPs.

The majority of the duty doctor's day was made up of urgent appointments to help meet demand. This role also coordinated visits and attended the intermediate care multi-disciplinary team meeting each week.

The practice had appointment templates so that sufficient time was booked depending on the nature of the consultation i.e. health reviews, immunisations and long acting reversible contraception (LARC) procedures.

Following feedback from patients and the patients reference group, the practice had responded and ensure that it remained open at lunchtime periods.

The practice housed other services, namely midwives, podiatry and health visitors and their appointments with the GP and other services was co-ordinated

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services and GPs who spoke other languages. The practice provided equality and diversity training. Staff we spoke with confirmed that they had read the 'Patient Dignity Policy' and that 'Equality & Diversity Policy' was discussed at staff appraisals and team events. The premises and services had been adapted to meet the needs of people with disabilities. This included lowered windows for wheel chair users at the reception desk.

The practice staff were aware of the needs of more vulnerable patients who may not normally have easy and regular access to GP services, for example homeless or transient patients.

The practice manager told us they had very small numbers of patients from different ethnic backgrounds, namely Pakistani and Eastern European people and a small number of patients from other Ethnic minorities. Most of

Good

Are services responsive to people's needs?

(for example, to feedback?)

these patients could speak English but interpreting services were available if required. The practice were looking into installing a hearing loop system for use by patients with hearing difficulties.

Where patients had specific needs, clinicians were aware and "go the extra mile" to ensure they received the right care at the right time. We spoke to the service advisor who was able to give an example of this and told us about how they contacted a patient with memory problems numerous times in the run up to their appointment to ensure they attended.

Patients with complex needs, like dementia or a learning disability, were identified on their clinical record. Learning disability reviews were co-ordinated by the practice nurse so that the patient had both nurse and GP care in one visit. Patients with dementia had a comprehensive annual review which included their social, physical and psychological well-being and also took into account the needs of carers. The use of templates ensured consistency and thoroughness of reviews and good record keeping.

One of the service advisors was a signer and they also had staff members who spoke Urdu, Punjabi and German. The practice used relatives wherever possible to interpret messages to patients however when this was not possible, they use a telephone language interpreter service.

Access to the service

Appointments were available from 8am to 6pm on weekdays. Multiple pre bookable appointments were available up to 28 days in advance. No one was turned away. Both clinicians and service advisors could book appointments. Clinicians would use their discretion booking follow up appointments for patients by booking them into embargoed slots to prevent delays.

When samples were taken, the patient's consent was obtained for receiving the results by text message. This ensures minimal delay if a follow up appointment was needed.

In the main clinics ran on time however when delays occurred, patients were advised by the service advisor or at self-check-in. Patients were given the option of re-booking should they so wish.

Comprehensive information was available to patients about appointments in reception and on the website. This included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were happy with the appointment system. This ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice.

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

The practice utilised a telephone based system to organise appointments. The practice also catered for walk in cases and people who do not have access to a phone. Reception staff are the first point of contact for patients. They are trained to take demographic data and brief medical details. Patients may be offered a routine appointment, a same day or an urgent appointment.

Patients can book directly into nurse appointments or they may be contacted by reception to book appointments for chronic disease management. The nurses had recently started to provide a telephone follow up service for chronic disease management which they told us was proving popular with patients.

Patients told us that when they needed urgent attention they were able to see a GP on the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager responded to complaints offering the patient the option to come in and discuss the issue. The manager contacted the GP concerned and the item was discussed at the weekly team meeting. We looked at the summary of complaints which provided an outline of the complaint, the outcome and the completed action and learning for the practice.

There were posters in the waiting area, information on the display screen as well as the policy on line and in the practice leaflet advising patients how to raise any concerns or make a complaint. Patients could also obtain a copy of the 'Patient Complaint Leaflet' at reception on request.

All complaints were handled by the practice manager and these could be in writing, on-line or letter, in person or by telephone. Clear timescales were set out in the complaint policy and these were always adhered to using a diary system. The practice operated a culture of openness and upheld the statutory 'Duty of Candour' in correspondence with the complainant.

The practice held a complaints log which details the complaint, outcome of the investigation and lessons learnt.

Any changes to practice as a result of a complaint, was communicated and implemented immediately through team meetings with those it affected. All lessons learnt were discussed practice-wide on an annual basis during a PLT (Protected Learning Time) and documented accordingly. Complaints and significant event analysis reviews were taking place at protected learning time.

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 recently engaged in consultation with an external company. As a result the practices vision and values were proposed. Staff were engaged and a shared vision was developed.

The result was the practice had a clear vision to deliver high quality care and promote good outcomes for patients. We were told details of the vision and practice values were part of the practice's business plan.

The practice has a mission statement which stated:-

"Our purpose is to provide people registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. We aim to achieve this by developing and maintaining a happy, sound practice which is responsive to people's needs and expectations and which reflects whenever possible the latest advances in Primary Health Care".

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The staff team understood and shared the vision for the practice and the GP partners had agreed the strategic approach of the business, we saw evidence of documented planning which supported their decision making. We saw a copy of the Business Continuity Plan dated March 2015.

Whilst the practice prided itself on the high quality of care it delivered to its population as well as achieving good results for QOF and QIPP (Quality, Innovation, Productivity and Prevention) schemes.

The practice was currently seeking views from staff about what they feel the vision and values of the practice should be so that a clear strategy for its achievement could be put in place. This would form the backbone of annual appraisals and individual objectives. These would be pulled together and agreed at the next protected learning time (PLT) session.

It's was agreed following consultation with staff that annual appraisals would be pushed back to June so that these could be incorporated into a new appraisal format.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the IT system. All the policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings. We looked at minutes from the last meeting and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain and improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk register which addressed a wide range of potential issues. We reviewed the comprehensive range of risk assessments. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of legionella bacteria. All risk assessments had been recently reviewed and updated.

Leadership, openness and transparency

The four GP partners had their differing strengths to support staff and the practice to move forward, for instance a GPs personnel skills, premises management, financial intelligence and mentoring. All of these skills were aligned with a clear ethos of delivering high quality care to patients and to be a supportive employer.

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

The practice had gathered feedback from patients through annual patient surveys, comment cards, suggestion box and complaints received. We looked at the results of the annual patient survey and were shown a report on comments from patients.

The practice had an established Patient Reference Group (PRG) who contributed and fedback patient views. The practice found these comments extremely useful as a tool for reflection and helping to improve patient experience. Currently there were 22 members.

The PRG met quarterly. Last year they helped the practice to embed the new local telephone number, promote

Are services well-led?

Good

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

on-line appointments and improve the patient display screens to be more reactive and informative. In March 2015 they added another question to the Friends and Family Test to allow patients to suggest changes so they could adapt delivery of the service to meet the needs. These results were currently being analysed by the patient champion. The results and actions agreed from these surveys and the seasonal newsletter would be available on the practice website.

The 'Friends and Family Test' (FFT) that commenced in December 2014 had given the practice excellent feedback of the services. The comments shown on the practice notice board in reception were a snapshot of those received so far. Patients could currently complete the FFT on paper or on-line. The practice were planning to purchase an electronic tablet device in the next couple of months so that patients can also use this to give them their feedback. They will use a commercial tool that also includes 2-way text messaging. The practice are planning to use this for FFT plus invites for reviews or immunisations like flu and shingles.

National Patient Safety results 2013/14 were acted upon by making two changes; opening more on-line appointments and clearly advertising the private area in reception. The survey dated 19 June 2014 to 31 March 2015 showed that 68 forms had been returned. Sixty one of these would recommend the practice to friends or family.

The practice had gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw minutes of a meeting where improvements were discussed and an action was agreed by all staff.

The practice had a whistle blowing policy which was available to all staff within the practice. Staff were aware of the structure within the practice for raising concerns and the Whistleblowing Policy enforced this formally. The practice very much operate on a "if we don't know about it, we can't do anything about it" message to staff to help encourage them to raise any issues.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice offered all GPs and nurses time to develop their skills and competencies. Staff who we spoke with confirmed this time was available. Staff also told us they were actively encouraged to take study time.

Systems were in place for recording and monitoring all staff training needs. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes.

The practice took part in an innovation scheme called 'Productive General Practice' in 2013/14 which helped to grow a culture for innovation and looking at things differently. This culture had continued and staff regularly suggested changes to process and challenge how and why things were done.

The PLT was used for staff to reflect on issues in particular the review of complaints and incidents allowed for operational reviews. They also used the PLT to reflect on how the practice teams work together and independently and how this can be improved and/or strengthened.

In March 2015 the practice engaged with a 'CQC Readiness Visit' by the NHS Calderdale clinical commissioning group. This was a fee based service and the visit was conducted by the 'West Yorkshire Audit Consortium'. We looked at a copy of the audit, summary findings and detailed findings. The practice had completed the recommendations made. This demonstrated the practice was open and transparent and listened, reflected and took action where appropriate.