Dr N Hayward and Partners, known as Shipley Medical Practice

Quality Report

Shipley Medical Practice
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Date of inspection visit: 17 February 2015
Date of publication: 18/06/2015

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 an announced inspection visit on 17 February 2015 and the overall rating for the practice was good. The inspection team found after analysing all of the evidence the practice was safe, effective, caring, responsive and well led. It was also rated as good for providing services for all population groups.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- 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 staff were caring and respectful; they were involved in their care and decisions about their treatment.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- Patients said they found it easy to make an appointment, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- The practice recognised patients may struggle reading electronic screens or navigating to consulting rooms. Therefore, all GPs and nurses personally collected their patients from the waiting room.

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- To help minimise the disruption to the routine of new mothers and their babies, they were offered combined postnatal and baby appointment, together with baby immunisations.
- The practice hosted the North Bradford Drug Service; one of the GPs partners had received additional training in this area and was a Substance Misuse and a Drugs Service prescriber. This helped improve clinical services for patients by reducing delays, improving access and keeping care closer to home.
- Where patients who had dementia were attending the practice for an appointment, the practice phoned them on the day as a reminder.
- The practice collected for a community food bank for people in acute need. Access to translation services and a hearing loop were available when required.

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 to report incidents and near misses. There were standard operating procedures and local procedures in place to ensure any risks to patient's health and well-being was minimised and managed appropriately. The practice learned from incidents and took action to prevent recurrence. Medicines were stored and managed safely. The practice building was clean and systems were in place to oversee the safety of the building.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' received care and treatment in line with recognised best practice guidelines such as the National Institute for Health and Care Excellence. This included assessing capacity and promoting good health. Their needs were consistently met and referrals to secondary care were made in a timely manner. The practice worked collaboratively with other agencies to improve the service for patients.

Are services caring?

Good

The practice is rated as good for caring. The patients who responded to CQC comment cards and those we spoke with during our inspection, gave positive feedback about the practice. Patients said staff were helpful, respectful, and supportive of their needs. When decisions were needed about their care, they were kept informed and received a caring service. We also saw staff treated patients with kindness and respect, and maintained their confidentiality. The practice realised when patients visited, they were not all able to read the electronic screen, or independently navigate to consulting rooms. Therefore, all GP's and nurses walk to the waiting room to collect their patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population. It engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services, where these were identified. The practice was responsive when meeting patients' health needs. There

Summary of findings

were procedures in place which helped staff respond to and learn lessons when things did not go as well as expected. There was a complaints policy and staff knew the procedure to follow should someone want to complain.

Are services well-led?

The practice is rated as good for being well-led. 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 meetings. Patients and staff felt valued and a proactive approach was taken to involve and seek feedback from patients and staff, which was acted on.

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. The practice made provision to help ensure care for older patients was safe, caring, responsive and effective. All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Good information was available to carers.

People with long term conditions

Good

The practice is rated as good for the population group of patients with long term conditions. There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible; with flexible appointment times every day of the week and late night evening appointments on Thursdays. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education meant they were able to ensure best practice was being followed.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young patients. They helped to ensure care for these patients was safe, caring, responsive and effective. The practice provided family planning clinics, childhood immunisations and maternity services. To help minimise the disruption to the routine of new mothers and their babies, they were offered combined postnatal and baby appointment, together with baby immunisations. They had a dedicated breastfeeding room, and a play area in the waiting room. There was health education information in the practice and on their web site to keep people informed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age patients including those recently retired. They helped to ensure care for these patients was safe, caring, responsive and effective. The practice had extended hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was an online booking system for appointments, and patients were sent appointments reminders the

Summary of findings

day before via text. Students, who had grown up using the practice, could be seen as temporary residents during holidays. A full range of health promotion and screening clinics were available and these reflected the needs of this population group

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with learning disabilities. They hosted the North Bradford Drug Service; one of the GPs partners had received additional training in this area and was a Substance Misuse and a Drugs Service prescriber. This helped improve clinical services for patients by reducing delays, improving access and keeping care closer to home. The practice allowed patients to register who were homeless/ in temporary accommodation. They also collected for a community food bank for people who were in acute need. Access to translation services and a hearing loop were available when needed.

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 helped to ensure care for these patients was safe, caring, responsive and effective. A memory assessment clinic was hosted at the practice. Screening and diagnosis with support was done in a timely way. A named GP carried out regular ward rounds at a care home for patients with dementia of early onset, and at each care home that accommodated their patients with dementia. Where patients who had dementia were attending the practice for an appointment, the practice phoned them on the day to remind them. The practice had a higher than national prevalence of patients with enduring mental health problems. Regular health checks were offered, including home visits for those within sheltered accommodation and care settings. They had good communication with the local psychiatry team, and medication changes were actioned when needed, within one working day.

Summary of findings

What people who use the service say

We received 24 completed patient CQC comment cards where patients shared their views and experiences of the service. We also spoke with a patient and they were a member of the Patient Participation Group (PPG).

Feedback showed, patients found staff were professional, respectful, and supportive of their needs and in decisions about their care. They were kept informed, received a caring service, and they would recommend the practice to other patients. With the exception of one patient who had experienced a 30 minutes delay of an appointment time, other patients reported the service was good.

Responses to the NHS patient survey identified: The GP and nurses were good or very good at treating patients with care and concern. Patients stated they almost always see or speak to the

GP they prefer and described their overall experience of their GP surgery as fairly good or very good.

Areas for improvement

Outstanding practice

- The practice recognised patients may struggle reading electronic screens or navigating to consulting rooms. Therefore, all GPs and nurses personally collected their patients from the waiting room.
- To help minimise the disruption to the routine of new mothers and their babies, they were offered combined postnatal and baby appointment, together with baby immunisations.
- The practice hosted the North Bradford Drug Service; one of the GPs partners had received additional training in this area and was a Substance Misuse and a Drugs Service prescriber. This helped improve clinical services for patients by reducing delays, improving access and keeping care closer to home.
- Where patients who had dementia were attending the practice for an appointment, the practice phoned them on the day to remind them.
- The practice held a food bank for patients visiting the surgery and in acute need. Access to translation services and a hearing loop were available when needed.

Dr N Hayward and Partners, known as Shipley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. The team included a GP and a practice manager.

Background to Dr N Hayward and Partners, known as Shipley Medical Practice

Shipley Medical Practice is located at Shipley Health Centre, Alexandra Road, Shipley, Bradford.

The practice has two general practitioner (GP) partners, five salaried GPs, a GP re-trainee, and two GP trainees (seven female and three males in total). Working alongside the GPs are three practice nurses, two health care assistants (all female) and an experienced management team of a practice manager, and administration/reception staff.

The practice has a Personal Medical Services (PMS) contract. PMS is a locally agreed alternative to General Medical Service (GMS) for providers of general practice. Their registered list of patients is 8,000.

The main practice opening times are Monday, Tuesday, Wednesday, and Friday 8am to 6.30pm, and Thursday 8am to 1pm, and 4pm to 8pm. The practice is closed every Thursday between 1pm to 4pm for staff training.

When the practice is closed, urgent healthcare advice that is not a 999 emergency is provided by telephoning the local Out of Hours NHS 111 service. This service is available 365 days a year and is free of charge.

A wide range of services are available at the practice and these include: vaccinations and immunisation, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England local area team and Bradford Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced inspection visit on 17 February 2015. During our inspection we spoke with staff including two GPs, an advanced nurse practitioner, the practice manager, and administration/reception staff.

We spoke with a patient who was a member of the Patient Participation Group (PPG), and observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 24 CQC comment cards where patients had shared their views and experiences of the practice.

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
- 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

Good

Are services safe?

Our findings

Safe track record:

The practice had systems in place to record, monitor and learn from incidents which had occurred within the practice. Safety was monitored using information from a range of sources. These included the Quality and Outcomes Framework (QOF), patient survey results, the Patient Participation Group (PPG), clinical audits, professional development, and education and training.

Staff were able to give examples of the processes used to report, record and learn from incidents. They confirmed these were discussed in the clinical, management meetings and with relevant staff.

Learning and improvement from safety incidents:

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was a record of 27 significant events which had occurred during the last year. The information has been analysed and main trends had been identified. We were told all significant events were brought to the monthly clinical team meetings, and learning from the incidents was discussed and passed to other staff in the team where appropriate. The information, including any action points were recorded on the Significant Event Analysis (SEA) template and reviewed at their practice team learning event, which occurred twice a year. We looked at notes of a SEA which had taken place on the 29 January 2015. The meeting had been held as a learning event. Twenty six staff including GPs, nurses, administration and reception staff had attended the event, and had been divided into four groups. Each group of staff were given a mixture of key themes to discuss. On the day of our inspection, the administration/reception staff confirmed they had attended the meeting in January 2015. They also told us learning at the event was fed back to all groups of staff. This was confirmed by the GP, practice nurse and manager. Staff, including receptionists, administrators, and clinical staff, knew how to raise issues and they felt encouraged to do so.

We were told by the practice manager; safety alerts were emailed to clinicians and relevant staff, and discussed at their meeting, together with the action taken.

Reliable safety systems and processes including safeguarding:

There were policies and protocols for safeguarding vulnerable adults and children. The practice nurse confirmed these were accessible on the practice computer system for all staff and a copy kept on their notice board. Staff had received safeguarding vulnerable adults and children training relevant to their role, and this included level three for safeguarding lead GPs. We saw a safeguarding 'achievements so far' report following an incident, dated 5 November 2014. The documentation stated the main safeguarding lead had completed e-learning in July 2014 and had their clinical face to face update in September 2014.

We were told further staff had been booked to attend the level three training later this year, and all practice nurses and health care assistants were to attend a one day course on 'Recognising and Responding to Abuse. We asked members of medical, nursing and administrative staff about their most recent training. They knew how to recognise signs of abuse. They were also aware of their responsibilities and this included how to contact the relevant agencies. The safeguarding contact details were easily accessible to all staff.

There was a system to highlight vulnerable patients on the practice's computer records system. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. This was to ensure risks to children and young people, who were looked after or on child protection plans, were clearly flagged and reviewed. Records and minutes of meetings demonstrated, adult and children safeguarding meetings took place and issues had been followed up by identified staff. There was frequent liaison with partner agencies such as, health visitors who visited the practice weekly, and social services.

In the practice waiting room we saw information offering the use of a chaperone during consultations and examinations. (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.) Staff told us they asked if patients would like to have a chaperone during an examination and this information was recorded on the computerised system. Staff also told us when chaperones were needed the role was carried out by

nursing or reception staff who had received training. Following the inspection we received information confirming the chaperone policy clearly reflected chaperones would never be left alone with a patient.

Medicines management:

A representative from the Bradford CCG Medicines Team supported the practice and gave advice on safe, effective prescribing of medication. This included the checking and advising on medicines that needed regular monitoring and reviewing, such as Warfarin. They also monitored and audited medicines to ensure the practice followed good practice guidance, published by the Royal Pharmaceutical society. Data showed the practice were in line with other practices in the CCG area for the prescribing of non-steroidal anti- inflammatory drugs, such as naproxen and ibuprofen.

The GPs monitored patient's medicines and this included those patients who were discharged from hospital. We were also informed by staff and patients we spoke with, that their medication was reviewed every six to 12 months or more often depending on their individual condition.

Repeat prescriptions were available via email, fax, through the post using a stamp addressed envelope, in person by using the prescription box at the surgery, or by using the ordering/collection service at the chemist.

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had arrangements for managing medicines to keep patients safe. Correct procedures were followed for the prescribing, recording, dispensing and disposal of medicines.

Vaccines were stored in locked refrigerators. Staff told us the procedure was to check the refrigerator temperatures every day and ensure the vaccines were in date and stored at the correct temperature. We were shown their daily records of the temperature recordings and the desired refrigerator temperatures for storage were maintained.

Cleanliness and infection control:

We saw there were cleaning schedules and daily cleaning took place, five days a week by employed staff. The practice manager told us as part of monitoring the cleanliness of the practice they met with the cleaning supervisor each week. We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

A practice nurse had a lead role in infection control. We saw there was an infection control policy and supporting procedures, which were accessible to staff. These included areas, such as hand washing and cleaning of equipment. There was a policy for needle stick injury; staff we spoke with confirmed their understanding.

Equipment:

We saw equipment was available to meet the needs of the practice and this included: a defibrillator and oxygen, which were readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw equipment had up to date annual, Portable Appliance Tests (PAT) completed. (Last tested, 15 December 2014.) Systems were in place for routine servicing and calibration of medical equipment where required. (Last tested, August 2014.)The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment:

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager told us how they reviewed and discussed these in the team meetings when new staff were needed. There was a system in place for the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's sickness and annual leave.

Recruitment records were not all seen on the day of inspection. Following the inspection we received information confirming appropriate recruitment checks had been carried out prior to employment. For example, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) where appropriate.

Monitoring safety and responding to risk:

The practice had clear lines of accountability for patient care and treatment. Each patient with a long term condition and those over 75 years of age had a named GP. The GPs, nurses and practice manager also had lead roles in areas such as, safeguarding, medicine management, infection control and management of long term conditions (LTC). Each lead had systems for keeping staff informed and up to date/using the latest guidance. For example, safety

alerts were circulated to staff and relevant changes made to protocols and procedures within the practice. The practice manager and staff told us safety alerts were discussed at staff meetings where the information was reinforced.

The practice had risk assessments in place and the sample we inspected included fire, infection control and Health and Safety. Each one had been reviewed and was in date. Information relating to safeguarding was displayed and staff had received relevant training.

Arrangements to deal with emergencies and major incidents:

There was a business continuity and management plan to help ensure the smooth running of the practice in the event of a major incident. (This was in date and with a review date of July 2015.)These included the loss of electrical or telephone systems. Staff were aware of the protocols should an incident occur and this included emergency contact numbers. We saw a copy of the document was available on the staff notice board and also on the practice computerised system for staff to access.

The GPs, nurses and practice manager had lead roles such as safeguarding, medicine management and infection control. Each lead had systems for keeping staff informed and ensuring they were using the latest guidance. For example, safety alerts were circulated via email to relevant staff, changes were made where appropriate to protocols and procedures within the practice. The practice manager and staff told us the alerts were discussed at relevant staff meetings where the information was reinforced.

Staff members spoken with confirmed they had received training in medical emergencies including resuscitation techniques. All staff were trained in basic life support and the clinical staff in the treatment of anaphylactic shock (severe allergic reaction).

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment:

We found care and treatment was delivered in line with CCG and recognised national guidance, standards and best practice. For example, the clinicians used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as asthma. We were told any updates were circulated and reviewed by the clinicians, changes made as required and these were discussed at the team meetings as appropriate.

There were systems in place to ensure patients with multiple conditions received one annual recall appointment wherever possible. This helped to offer the patient a better overall experience in meeting their needs. Healthcare professionals were skilled in specialist areas and their on-going education meant they were able to ensure best practice was being followed.

The practice had registers for patients including those needing palliative care, diabetes, asthma, COPD, dementia, and learning disabilities. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed.

Protocols were available and used to assist staff in maintaining the treatment plans of their patients. The practice used standardised local/national best practice care templates as well as personalised self-management care plans for patients with long-term conditions.

The practice raised awareness of health promotion during consultations with GPs and nurses. The nursing team carried out health checks and gave advice on family planning, diet, smoking, alcohol and stress. Health promotion literature was also available and visible in the treatment rooms, the practice waiting areas and was brought to patients' attention through the practice website.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people:

We found there were mechanisms in place to monitor the performance of the practice and the clinician's adherence with best practice to improve outcomes for people.

We saw the practice had a system in place for monitoring patients with long term conditions (LTC) and this included asthma, hypertension, Chronic Obstructive Pulmonary Disease (COPD), diabetes and learning disabilities. Care plans had been developed and they had incorporated NICE and other expert guidance.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF aimed to improve patient outcomes for a range of conditions such as diabetes. The practice used the information they collected to help monitor outcomes for patients and the quality of services they provided. For example, the QOF data showed the practice scored better than average for maintaining a register of patients aged 18 or over with learning disabilities.

We saw evidence that audits, learning, updates and action taken were monitored and shared at their clinical meetings. Other audits we saw evidence of and which were carried out by the practice included, assess and the appropriateness of clinical appointments, post natal care of patients with gestational diabetes and medication, for example, the monitoring of patients on amitriptyline.

Effective staffing:

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

The practice was a training practice for doctors who were training to be qualified GPs and they were supported by the GP partners and practice staff.

The practice manager told us all staff received general induction training with them when joining the practice and

Good

Are services effective?

(for example, treatment is effective)

this included access to policies and procedures. Staff confirmed, new staff were provided with induction training and mentors. They were able to access relevant up to date policy documents, procedures, guidance and training.

Two out of four staff who had been working at the practice for several years, told us they had annual appraisals where they identified their learning needs. They also told us they had received a record of their appraisal and it had been signed. One of the clinical staff told us they had a date booked for their appraisal to take place, whilst a second clinician told us they had not had an appraisal for some time. However, this person also told us they were kept up to date by the practice with mandatory training and any training they needed to carry out their role. They said they were actively supported in their role. The practice manager confirmed they were behind on some of the formal appraisal meetings and steps would be taken to address this in the near future.

The practice had procedures in place to help ensure all staff kept up to date with both mandatory and non-mandatory training. These included training in, safeguarding vulnerable adults and children and basic life support. Staff confirmed they had received training specific to their roles, for example, vaccinations and immunisation training, cervical smears, spirometry, and this included any updates.

Working with colleagues and other services:

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with multi-disciplinary teams within the locality.

Multidisciplinary meetings were held to discuss patients on the palliative care register and support was available irrespective of age. The QOF data showed the practice scored better than average (when compared to other practices in the CCG area) for having at least three monthly, multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Staff we spoke with felt they were listened to and involved in the running of the practice. There were clear lines of accountability and staff understood their roles.

The practice had systems in place to monitor if patients attended appointments where they had been referred by the practice to secondary care services such as the hospital. Where the practice was informed the patients had not attended an appointment they would follow this up with the patient.

They had good communication with the local psychiatry team and medication changes were actioned when needed, within a working day.

The practice also liaised and worked with other community staff, including midwives, who worked at the ante natal clinic which was held at the practice.

The practice staff engaged with the community and local groups. For example, the practice manager met three monthly with the Shipley Neighbourhood Forum. The group consisted of people in the community, councillors, MPs and police, and they discussed issues such as, how they could influence and improve the health needs of the community.

Procedures were in place to manage information from other services such as the hospital or out of hours services. Staff were aware of their responsibilities when they processed discharge letters and test results. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff.

Information sharing:

The practice had details informing patients of how their records were held on a computerised, secure, clinical system which complied with the Data Protection Act 1998. The information explained how the system kept a register of patients with long term health problems like diabetes, asthma, heart disease or mental health problems. It also stated patients had the right to refuse to be on such a register and were to contact them if they wished to be removed.

Consent to care and treatment:

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity (at age 16yrs or younger) to make decisions about their treatment.

Good

Are services effective?

(for example, treatment is effective)

Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were conducted.

Health promotion and prevention:
All new patients were offered an appointment with one of the practice nursing team for an examination and health check.

All patients over 75 years had a named GP and received an annual health check. Patients with a long term condition or mental illness had an annual review of their treatment, or more often where appropriate. Dementia screening also took place.

A well-baby clinic was run by a Health Visitor held every Wednesday between 1pm and 3pm, and no appointment was necessary.

A number of clinics were available through appointment only and these included the Healthy Heart clinic, Drug clinics, and the Alcohol Support service.

Other health promotion and prevention services (appointments only, with a doctor or Practice Nurse) included,

- Advice about healthy eating and help to lose weight.
- Help to stop smoking.
- Immunisations (including foreign travel).
- Cervical smear tests and 'Well Woman' checks.

The practice had a range of health information leaflet displayed in the practice informing patients about self-treatment of common illnesses and accidents. Their web site promoted information about how to become healthy and the treatment of minor illnesses, which included video information. The web site information included conditions such as, diarrhoea, coughs and colds, and first aid.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy:
Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in rooms which gave patients privacy and dignity. Patients told us they were treated with dignity, respect and compassion whilst they received care and treatment. For example, staff told us they realised when patients visited the practice, they were not all able to read the electronic screen, or independently navigate to consulting rooms. Therefore, all GP's and nurses now walked to the waiting room to collect their patients, and we observed this taking place at the time of the inspection.

Where patients who had dementia were attending the practice for an appointment, the practice phoned them on the day to remind them.

Care planning and involvement in decisions about care and treatment:
The patients we spoke with said they had been involved in decisions about their care and treatment. They told us their treatment was explained to them and they understood the information.

Care plans were in place for patients with specific health needs and these included patients with long term conditions such as, asthma. They were adapted to meet the needs of each individual. This information was designed to help patients to manage their own health, care and wellbeing to maximise their independence and also help reduce the need for hospital admission.

Patient/carer support to cope emotionally with care and treatment:
We saw information in the practice about advocacy, and bereavement support services. Staff were aware of contact details for these services when needed.

Comments on the CQC patient comments cards stated, staff were supportive of their needs, in decisions about their care, and they received a caring service. The NHS patient survey also identified: The GP and nurses were good or very good at treating patients with care and concern.

The QOF data showed, in line with National targets the practice had regular (at least 3 monthly) multidisciplinary case review meetings. All patients on the palliative care register were discussed in relation to their care and support. This helped to ensure they received coordinated care and support.

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 patient'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 in the way services were delivered.

We were also told one of the GP partners was a member of the Bradford Clinical Commissioning Group (CCG). As such, they engaged with other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was accessible to patients with mobility difficulties. The consulting rooms were large with easy access for patients with mobility difficulties. There were toilets for disabled patients.

There was a baby changing area, and a small play area for children visiting the practice.

In meeting the needs of patients the practice had access to translation services and some of the staff were able to speak a language other than English for example, Polish. The practice website also was available in languages other than English.

Tackling inequity and promoting equality:

The practice had recognised the needs of different groups in the planning of its services. For example, they hosted the North Bradford Drug Service; one of the GPs partners had received additional training in this area and was a Substance Misuse and a Drugs Service prescriber. This helped improve clinical services for patients by reducing delays, improving access and keeping care closer to home.

The practice had extended opening hours on a Thursday until 8pm. This allowed for flexible access for patients including working age patients and those in full time education.

Students, who had grown up attending the practice, could be seen as temporary residents during holidays.

All patients over 75 years had a named GP. There were systems in place for older patients to receive regular health checks, and timely referrals were made to secondary (hospital) care. Information was available to carers and the practice kept a register of these patients.

The practice collected for a community food bank for people in acute need. Access to translation services and a hearing loop were available when needed.

To help minimise the disruption to the routine of new mothers and their babies, they were offered combined postnatal and baby appointment, together with baby immunisations.

Access to the service:

Information was available to patients about appointments in the waiting room and on their website.

Patients could telephone, visit the practice, or make an appointment on line. There was a duty doctor on call; telephone call back appointments were available, and included the availability of an urgent, on the day appointment. Patients we spoke with told us this system worked well and they were able to have an appointment on the same day when needed.

The practice opening times were Monday, Tuesday, Wednesday, and Friday 8am to 6.30pm, and Thursday 8am to 1pm, and 4pm to 8pm. The practice was closed every Thursday between 1pm to 4pm for staff training.

When the practice was closed, urgent healthcare advice that was not a 999 emergency was provided by telephoning the local Out of Hours NHS 111 service. The service was free and available 365 days a year.

Listening and learning from concerns and complaints:

The practice had a system in place for handling complaints and concerns, and staff were aware of the procedure to follow. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice had a designated person who handled all complaints and this was the practice manager.

We saw information was available to help patients understand the complaints system and this was seen in the form of a poster and leaflet, located in the practice waiting room. Patients we spoke with told us they had never had to complain and should they need to, they would speak with the staff.

We saw the practice used a computer system to log their complaints. Ten complaints had been received by the practice from April 2013 to 31 March 2014 and they were

Good

Are services responsive to people's needs?

(for example, to feedback?)

responded to in line with the practice procedure. They had also respected the wishes of the patients who had complained and this included feedback by telephone, letter and in person.

Staff told us the outcome of complaints and learning was discussed where appropriate at their team meeting however, we did not see these records at the time of inspection.

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:
There was an established management structure within the practice. The practice manager, GP's and staff were clear about their roles and responsibilities and the vision of the practice. They told us they were a friendly, caring and non-judgemental practice, and were committed to the delivery of a high standard of service and patient care.

Governance arrangements:
The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. It also showed they were achieving in the upper quartile in having regular palliative care meetings, maintaining a register of patient needing palliative care, and those over 18 years of age with a learning disability.

Leadership, openness and transparency:
There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. All staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued and supported, and knew who to go to in the practice with any concerns.

Staff we spoke with told us all members of the management team were approachable, and appreciative of their work. They had a proactive approach to incident reporting. Meetings were held and this included those with clinicians, nursing staff, and information was shared with the non-clinical staff where appropriate.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals; for example, district nurses and health visitors.

Practice seeks and acts on feedback from its patients, the public and staff:
As noted earlier the comment cards we received showed that patients felt the practice provided good, patient centred care.

Responses to the NHS patient survey identified: The GP and nurses were good or very good at treating patients with care and concern. Patients stated they almost always see or speak to the

GP they prefer and described their overall experience of their GP surgery as fairly good or very good.

The practice had gathered feedback from patients through the Patient Participation Group (PPG), the practice survey, Friends and Family Test, and the NHS patient surveys.

We looked at the results of the annual patient survey which was available to patients. The information related to what patients had said about the service and an action plan as to how any issues would be addressed. For example, there was an action for the practice to look at access to the service in relation to appointments. We saw practice minutes of the meeting where the appointment system had been discussed (dated 22 January 2015). The information showed on the 12 February 2015 arrangements had been made to trial a new way to access the practice. When we inspected the practice, staff told us a new way to access the practice had been tested and it would be repeated later in the year; a full evaluation would then take place.

The PPG was made up of staff and patients from the practice and from another GP practice in Bradford, and they met six times a year. We saw information on the practice web site advertising the group; this was with a view to sharing their experiences and suggestion to improve the service. We also saw minutes of meetings, and a report on the progress, participation, outcomes and information related to improving the service.

The staff felt they could raise concerns at any time with either the GPs or their manager. They were considered to be approachable and responsive. Staff told us they felt involved in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement:
Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. All staff attended individual training to ensure they had the skills and competencies to do their job. For example, a practice nurse had attended vaccination and immunisation update training.

Are services well-led?

Good

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

We were told the practice staff learnt together with other GP practice, at monthly TARGET (Time for Audit, Research, Governance, Education and Training) days. They worked together to resolve problems, learn and share information to proactively improve the quality of services. Although we did not see an agenda, or a list of staff names who attended the learning day in January 2015; we did see documentation which showed the meeting had taken place.