Rooley Lane Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 comprehensive inspection at Rooley Lane Medical Centre on 11 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also rated as good for providing services for all population groups.

Our key findings across all the areas we inspected 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.
- Risks to patients were assessed and well managed.
- 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 was available and easy to understand.
- Patients said they found it easy to make an appointment, 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, which it acted on.

We saw two areas of outstanding practice:

Summary of findings

- There were outstanding systems to manage prescribing practice.
- There were outstanding systems for information governance.

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

Importantly the provider should

- Assess the risk to staff working alone.
- Improve patient experience of contacting the practice by telephone.
- Improve financial and maintenance planning.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. 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 patients safe.

Risks to lone workers had not been assessed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their role and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked well with multidisciplinary teams.

Systems to manage prescribing practice were outstanding.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population when developing service. They engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had reviewed their appointments systems and made improvements. Patients said they found it easy to make an appointment and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

Information about how to complain was available on the website and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Some patients told us they had difficulty they accessing the practice by telephone.

Are services well-led?

Good

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

Financial planning and review had not been completed.

The practice had outstanding information governance systems.

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 outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. 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 and end of life care. It was responsive to the needs of older people, and offered home visits. Regular visits to local nursing homes were also undertaken. Monthly multi-disciplinary meetings were held to review the care needs of older people. The practice worked closely with other health and social care organisations such as the community integrated care team and ran a number of in-house clinics where patients could obtain social care or benefits advice. Data showed that the practice was a high achiever for flu immunisation for this group of patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified and monitored. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to monitor patient outcomes and to deliver a multidisciplinary package of care. An advanced nurse practitioner had been employed to support patients with complex needs. The practice held a number of in-house clinics to support this group of patients such as warfarin monitoring, physiotherapy clinics and in house electrocardiogram (ECG) appointments.

We received a number of very positive comments about the support and care patients with asthma and chronic obstructive pulmonary disease (COPD) received.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Patients told us that children and young people were treated in an age-appropriate way and were recognised as

Summary of findings

individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked closely with other agencies such as the health visitors and support services for teenagers and held a number of in-house health and social care clinics.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Pre-bookable early morning appointments as part of the extended hour's scheme.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The main flu clinics were held on a Saturday to facilitate patients who worked to attend.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability and for those who required translation services.

The practice had a designated GP with the lead role for patients who had learning disabilities Two of the GPs had been presented with a 'Healthy Living Award' in 2014 for people with Learning Disabilities. They had been nominated for this by their patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It signposted vulnerable patients to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice held a number of in-house health and social care clinics to support patients such as benefits advisor, alcohol advisor and health trainer clinics.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health received an annual physical health check and longer appointments were available. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out pre-screening and care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and held in-house clinics. It had a system in place to follow up patients who had attended accident and emergency (A&E).

Summary of findings

What people who use the service say

We received 20 CQC comment cards and spoke with four 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.

Patients told us they were very satisfied with the service they received. They described the service as absolutely brilliant, excellent, first class, very good and a great service. A number of comments described the doctors, nurses and reception staff as caring, helpful and respectful.

The patients were complimentary about the care provided by the clinical staff. They told us the GPs listened to them, explained treatments to them and involved them in decisions about their care. We also received very positive comments about the nurses and we were told the nurses were very understanding and supportive. Patients described how well supported they were with their long term health conditions and they said they had been offered regular health checks. We received a number of very positive comments about the support patients received from nursing staff in relation to asthma and chronic obstructive pulmonary disease (COPD).

Patients told us all the staff treated them with dignity and respect

Patients told us they had difficulty getting through to the practice on the telephone but were complimentary about the availability of appointments. They told us since the new appointment system had been introduced they could always get a same day appointment if required. The patients said they could request to see a named GP although one person told us they had to strongly insist that was the person they wanted to see before being offered an appointment.

Patients said the practice was always clean and tidy.

We received information from the National Patient Survey. The information from the 2013 GP Patient Surveys showed 377 surveys were sent out and 134 patients responded. The results showed 81% rated their overall experience of this surgery as very or fairly good.

Areas for improvement

Action the service SHOULD take to improve

The risk of staff working alone had not been assessed and there was no policy and procedure to support safe lone working.

Patients experienced difficulty getting through to the practice by telephone.

A financial review and a financial plan for the future had not been completed and there was no maintenance plan for the practice.

Outstanding practice

There were outstanding systems to manage prescribing practice. We saw information relating to prescribing data for the practice. This showed patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were within expected levels. To assist them to monitor prescribing practice they employed a pharmacist. The pharmacist completed regular audits against key performance prescribing indicators. For example, the pharmacist completed a monthly audit to monitor prescribing trends of antibiotics by individual GPs in the practice. The audits mirrored the local and national initiatives to reduce prescribing of medicines which commonly show multi-organism resistance. The pharmacist also reviewed hospital discharge letters and ensured patients records had been updated with any medication changes. The practice had also worked with community pharmacists to improve systems for repeat prescribing.

Summary of findings

There were outstanding systems for information governance. There were clearly thought through information governance procedures in place. We observed adherence to the procedures by all the staff. We saw that the information governance lead GP had completed an audit of the information governance procedures. Following this audit improvement had been made to the procedures for destruction of confidential waste. They had also identified an issue with an external agency in relation to information governance and referred this back to them for action.

Rooley Lane Medical Centre

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 specialist advisor.

Background to Rooley Lane Medical Centre

Rooley Lane Medical Centre is situated within a purpose built health centre in Bradford.

The practice provides Personal Medical Services (PMS) for 6921 patients under a contract with NHS Bradford Districts Clinical Commissioning Group (CCG).

There are three GP partners and a salaried GP, two male and two female. The clinical team also includes a team of three practice nurses including an advanced nurse practitioner, a nurse prescriber and there is also a health care assistant. An experienced team of 15 management, administrative and reception staff support the practice.

The surgery opening times are Monday to Friday 8.00am to 6.00pm and there are extended opening hours four mornings per week from 7.00 to 8.00am.

Patients can access the appointment system by telephone, presenting at reception or on line via the practice web site. Some appointments are pre-bookable and some are allocated to be booked on the same day.

Local Care Direct provides out of hours services and is accessed via the practice telephone number. Calls to the practice are automatically redirected to this service outside of the practice opening hours.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice is registered to provide the following regulated activities; family planning, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 which is 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 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

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

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

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

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

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

We carried out an announced visit on 11 February 2015. During our visit we spoke with a range of staff including the three GP partners, a locum GP, advanced nurse practitioner, lead practice nurse, practice manager, IT manager, office manager, a health care assistant, five reception and administration staff, the pharmacist and domestic assistant. We also spoke with four patients who used the practice.

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 20 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included, reported incidents, national patient safety alerts, clinical audits and comments and complaints received from patients. The practice had processes in place to ensure that incidents would be reported, recorded and investigated. The majority of staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw records which showed the practice had managed incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice also had a designated lead GP in this area. Significant events were regularly reviewed during practice meetings and specific quarterly significant event review meetings were held. An annual practice meeting was also held where complaints and incidents from the previous 12 months were reviewed. There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise issues for discussion at the practice meetings.

The practice manager showed us the system they used to manage and monitor incidents. We looked at the records of incidents and saw records were completed in a comprehensive and timely manner and records of action taken were also maintained. For example, we saw that where there had been a failure in recording a diagnosis on patients records the procedures had been reviewed and changed to ensure that the risk of reoccurrence was minimised. There was no evidence that actions taken were reviewed to ensure that these had been effective.

Where patients had been affected by something that had gone wrong we saw, where applicable, action had been taken to protect patient's health and welfare.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all the staff had received training in safeguarding both adults and children. Record's showed training was provided at a level commensurate with role. Staff we spoke with were aware of their responsibilities and knew how to share information of concern. Safeguarding policies and procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had a designated lead GP in safeguarding vulnerable adults and children. They confirmed they had completed training at the appropriate level for this role. Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

Additionally GPs and the advanced nurse practitioner had also completed specific training on safeguarding children from abuse by sexual exploitation.

The practice held monthly safeguarding meetings with other agencies, such as the health visitor, to discuss concerns and share information about children registered at the practice.

A system was in place to highlight vulnerable adult patients on the practice's electronic patient record. Vulnerable adults who may be at risk were reviewed at the monthly multi-disciplinary meeting held by the practice.

Information was provided to patients about safeguarding adults and children and where to refer any concerns they may have.

There was a chaperone policy and procedure in place. We observed this document did not instruct staff who were chaperoning to stand inside a privacy curtain. This action is necessary to ensure staff could observe any procedures were carried out in an appropriate manner. However, staff we spoke with were aware totake this action. Information for patients relating to provision of chaperones was displayed in the practice and on the website. The nursing staff and health care assistants usually acted as chaperones when necessary and they had received training in this area. Some reception staff had also received training and had the appropriate recruitment checks to enable them to undertake this role if required.

Medicines management

Good

Are services safe?

Medicines were kept in a secure storage area, which could only be accessed by clinical staff. We saw that dedicated fridges were used to store medicines requiring refrigeration. Logs of the daily checks of the temperature of fridges had been maintained which showed these were within the recommended temperature ranges for the medicines stored. A protocol was readily available to staff to advise them on the action to take in the event of the fridge temperatures being outside of these recommended ranges.

We saw that medicines for use in emergencies were accessible to staff. We saw these medicines were in date and were routinely checked.

Requests for repeat prescriptions were taken by e-mail, online, post, via the local pharmacy or at the reception desk. Repeat prescriptions were signed by a GP and checks were made to ensure the correct person was given the prescription. There were procedures in place for GP reviews to monitor patients on long term medicine therapy.

There were procedures in place for the security of prescriptions. However we saw that completed prescriptions awaiting collection were not secure as they were stored near an open window area accessible to patients. These were moved immediately and the manager has confirmed to us in writing that new procedures had been put in place to ensure security of the completed prescriptions.

Any changes in guidance about medicines were communicated to clinical staff by the practice IT manager. The information was then discussed with staff at meetings.

Cleanliness and infection control

We observed the premises to be clean and tidy although where there were carpets in surgeries these were stained and worn. We also saw that some chairs in the waiting area and in surgeries were covered with material that could not be effectively cleaned and sinks and taps in surgeries did not meet current Department of Health guidance. An infection, prevention and control audit had been completed in November 2013 and January 2015. These issues had been identified in both audits as requiring action to minimise the risk of cross infection. The audit action plan stated these items were included on the maintenance plan. However the manager told us there was no maintenance plan and they could not tell us when this work was to be completed. The practice manager has since sent us a maintenance plan for the replacement of sinks, flooring and chair coverings. This informed us that carpets would be replaced by September 2015 and sinks and taps by April 2016. Chair coverings were planned to be changed as they required replacing.

We saw there were cleaning schedules in place but these did not include cleaning carpets other than vacuuming. The practice had not competed regular audits of the cleaning standards but had identified this as a shortfall in their January 2015 infection control audit. They were to implement monthly cleaning audits from February. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a designated lead nurse for infection control. The training log showed all the staff had received infection control training and staff we spoke with were aware of the procedures in place to minimise the risks of cross infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Hand washing sinks, antibacterial hand gel and hand towel dispensers were available in treatment rooms and hand gel was available for patients in the reception area.

The practice had a process for the management and testing of legionella (a bacterium found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

Staff we spoke with were aware of how to access equipment in an emergency and we observed that emergency equipment was easily accessible to staff. Records showed the equipment was checked regularly to ensure it remained in working order. We saw annual inspections of equipment were also completed.

We saw systems were in place for portable appliance tests (PAT) and calibration of equipment. We saw PAT had last been completed in November 2013. The practice fire risk assessment stated these tests should be completed annually. The practice manager told us they had planned

to have this completed when ongoing building work was completed however, they have since sent us written confirmation that the tests had now been scheduled for 18 February 2015.

Equipment used for minor surgical procedures was for single use only and the equipment we checked was within its expiry date.

Staffing and recruitment

The practice had recruitment policy and procedures. The documents identified the checks that were required for recruitment of clinical and non-clinical staff and the process to be followed to obtain these checks. For example, it included the type of proof of identification required, number of references, checking registration with the appropriate professional body and the criteria for criminal records checks through the Disclosure and Barring Service (DBS). We saw relevant checks were in place in the staff files we reviewed

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. A GP described how they ensured that there was sufficient cover to provide appointments for patients and the processes in place to manage annual leave.

Staff told us there was usually enough staff to maintain the smooth running of the practice. The practice took into account longer term succession planning for GP partners and the nurses and as vacancies arose they considered the team and skills required prior to recruitment. The practice manager told us that they also considered the staff team and skills required during appraisals and in their review of significant events. We saw evidence that workforce analysis was completed.

Administration staff told us staffing had been low due to long term sickness and other leave and staff morale had been low. They said this was improving and two new staff had recently been employed within the administration team. GPs told us they had had difficulty recruiting GPs; they said they had advertised locally and nationally and had received no suitable applications. They told us they used a small consistent group of locum GPs to provide a weekly session and to cover annual leave and sickness. They also said they were planning to become a training practice from August 2015 which they hoped would assist their recruitment process.

We received positive comments about the staff and patients told us they found all the staff to be caring and helpful. Patients also told us they could usually get an appointment the same day if required. We did receive some comments about how difficult it could be to get through to the practice by telephone. However, we found there were adequate numbers of staff to answer the phone for the number of lines coming into the practice.

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.

Risks were assessed and actions to reduce and manage the risk were recorded. For example, we saw that health and safety and fire risk assessments had been completed and action plans were in place to ensure any shortfalls were addressed. Staff had completed health and safety and fire safety training. However, we found that although some staff worked alone at times a risk assessment had not been completed and there was no policy and procedure to support safe lone working.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. We saw emergency equipment was accessible to staff including access to oxygen and an automated external defibrillator.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included contact numbers for services such as water, gas and electricity and included guidance for staff in the event of a major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told that when new guidelines were disseminated the implications for the practice's performance and patients were discussed and required actions agreed at the practice meetings. We were told the practice monitored changes in best practice guidelines and developed new protocols as required to ensure that best practice was implemented in a timely manner. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We were told the GPs were encouraged to develop individual areas of interest in specialist clinical areas and have lead roles in areas such as palliative care. The practice nurses supported this work through specific clinics in line with their own knowledge and skills which allowed the practice to focus on specific conditions. For example, one nurse ran the clinics for asthma and chronic obstructive pulmonary disease (COPD).

Clinical staff we spoke with told us they were well supported and said they shared information and felt able to ask colleagues for advice and support.

The data from the local Clinical Commission Group (CCG) relating to the practice's performance for antibiotic prescribing was comparable to similar practices. The practice employed a pharmacist to ensure best prescribing practice and they carried out monthly audits to monitor prescribing patterns.

The GPs we spoke with used national standards for the referral of patients with suspected cancers to be referred and seen within two weeks. Administration staff were able to describe the process for ensuring urgent referrals were managed effectively and had been processed.

Interviews with GPs showed the culture in the practice was that patient's clinical need was the basis for care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service.

The GPs told us their clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). We saw a list of the audits undertaken which included a number of medication audits, cervical cytology audit and a medical procedure competency audit. We looked at two of these in detail. One audit showed prescribing practice had improved and performance had been sustained over time. Another showed they had identified a group of patients whose risks to their health would be reduced by taking a particular medicine and had invited them for a review to discuss this.

We saw information relating to prescribing data for the practice. This showed patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were within expected levels. To assist them to monitor prescribing practice they employed a pharmacist. The pharmacist completed regular audits against key performance prescribing indicators. For example, the pharmacist completed a monthly audit to monitor prescribing trends of antibiotics by individual GPs in the practice. The audits mirrored the local and national initiatives to reduce prescribing of medicines which commonly show multi-organism resistance. The pharmacist also reviewed hospital discharge letters and ensured patients records had been updated with any medication changes. The practice had worked with community pharmacists to improve systems for repeat prescribing. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, systems were in place to ensure that patients receiving repeat prescriptions had been reviewed by the GP.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes, asthma, COPD and mental health. They were above the national average for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months and for patients with diabetes receiving the flu vaccination.

An advanced nurse practitioner had been employed to support patients with complex needs. The practice held a number of in-house clinics to support patients such as warfarin monitoring, physiotherapy clinics and in house electrocardiogram (ECG) appointments.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with essential training courses such as annual basic life support, fire safety and safeguarding adults and children.

GPs were up to date with their continuing professional development requirements and one GP we spoke with had completed their 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

Practice nurses and health care assistants were expected to perform defined duties and they were trained to fulfil these duties. Training for this group of staff was also targeted towards improving and expanding services for patients. For example, the health care assistant had undertaken training to support patients to stop smoking and training to take patients' blood.

Clinical staff told us they were well supported and said there were plenty of opportunities for clinical support and training.

Non-clinical staff also told us they were well supported and had access to training relevant to their role.

Working with colleagues and other services

The practice worked with other service providers and held regular multi-disciplinary meetings to monitor patients at risk; review patient's needs and manage complex cases. We saw health professionals, including health visitors and palliative care and community nurses, were invited and attended these meetings.

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 the GP would review the referral and follow this up with the patient.

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

Information sharing

The patient record system used in the practice and that used by the partner agencies, such as district nurses, was a shared system. Information about patients' needs was also shared, where required, at regular multidisciplinary meetings held in the practice. Clinicians from the practice told us they attended bi-monthly Community Integrated Care (CIC) meetings where information relating to patients needs was also shared. These meetings included multiple agencies, for example, voluntary agencies, social services, mental health and medicines usage advisors.

Electronic systems were in place for making referrals, and the GPs, in consultation with the patients, made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used the electronic patient record to coordinate, document and manage patients' care and policies and procedures were also available electronically. Regular practice meetings were held for staff

Good

Are services effective?

(for example, treatment is effective)

and we saw from the minutes that agenda items included information about changes to policies and procedures, training opportunities and learning points from complaints and incidents.

Consent to care and treatment

We found GPs were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We saw from the training log that training in this area had only been provided to one member of staff, a nurse, although the clinical staff we spoke with understood the key parts of the legislation.

Clinicians were able to give examples where consent for treatment had been discussed and mental capacity had been assessed. They also demonstrated a clear understanding of the assessment procedures to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. We saw these procedures had been reviewed and discussed as part of a recent clinicians meeting

Health promotion and prevention

The practice offered NHS Health Checks and was involved with the national breast, bowel and cytology screening programmes. They told us they were also participating in the Cardiovascular Disease (CVD) Champion for healthy hearts, Stroke Prevention In Atrial Fibrillation integrated care clinic programme.

and OK Diabetes research programmes.

The practice had numerous ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, chronic disease or mental health problem and these patients were offered an annual physical health check.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data showed they were above the local national average on the uptake of influenza immunisation.

The practice web site provided access to a wide range of patient information and links to other websites such as NHS Patient Information websites. The information on the practice website could be instantly translated in other languages via a translation programme. A range of health information leaflets were also displayed in the practice waiting area. Additional clinics and services were available for patients within the practice. These included benefits advice, anticoagulation clinic, alcohol advice, gateway worker sessions who signposted patients to services such as local mental health services and health trainer sessions who signposted patients to services such as local voluntary services.

The majority of patients we spoke with were very complimentary about the level of information they received about their treatments during consultations.

Two of the GPs had been presented with a ‘Healthy Living Award’ in 2014 for people with Learning Disabilities. They had been nominated for this by their patients.

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 national patient survey where, from 377 surveys, 134 responses were received. Data from the national patient survey showed 81% of patients rated the practice as very good or fairly good which was just below average for the local CCG of 84%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards which were very positive about their experience of the service. We also spoke with four patients on the day of our inspection. Patients said they were very satisfied with the service they received. They described the service as absolutely brilliant, excellent and first class. A number of comments described the doctors, nurses and reception staff as caring, helpful and respectful. Patients told us all the staff treated them with dignity and respect

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation / treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A side room was available for patients who wished to speak privately to reception staff. Records showed staff had received information governance and customer care training.

The practice main flu clinics were held on a Saturday to assist in the uptake from the elderly patients, as their families are then able to bring them.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and who completed CQC comment cards were complimentary about the care provided by the clinical staff. They told us the GPs listened to them, explained treatments to them and involved them in decisions about their care. We also received very positive comments about the nurses and we were told the nurses were very understanding and supportive.

Patients said their long term health conditions were monitored and they felt supported. One person described how well supported their child was with their long term condition and they said they had been offered regular health checks.

We were told care plans had been produced for patients with complex needs including those with mental health needs and those patients at high risk of admission to hospital.

Staff told us interpreter services were available for patients who did not have English as a first language and longer appointments would be booked when patients required this service.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting rooms and on the patient website informed patients how to access a number of support groups and organisations. Written information was available for carers to ensure they understood the various avenues of support available to them and carers were referred to carer's resource on initial registration with the practice. The web site had information and links to Bradford and Airedale team Carers Resource information, Family action Bradford and NHS carers direct.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us they engaged regularly with the local Clinical Commissioning Group (CCG) and one of the GPs was the practice CCG representative and attended meetings with the CCG regularly.

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 in the way services were delivered. The practice identified and recorded, at the point of registration, the patient's first spoken language and whether an interpreter would be needed. A record of vulnerable patients such as those with learning disabilities, mental ill health, nursing home patients and all housebound patients was maintained. If patients required an interpreter or had learning disabilities they were booked a double appointment to allow adequate time for discussion. The practice had a designated GP with the lead role for patients who had learning disabilities and annual health checks were offered for these patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, they had installed an electronic information board and provided pre-bookable early morning appointments as part of the extended hour's scheme.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs who may require a longer appointment. Home visits were offered and the GPs carried out weekly 'ward rounds' at a number of local nursing homes.

The practice was situated within a building which was purpose built. The patient areas were on the ground floor and the patient areas were sufficiently spacious for a wheelchair user. Toilets with baby changing equipment and equipment suitable for those with a disability were available. A second toilet with facilities for disabled patients was in the process of completion. The practice manager told us the practice did not have electronic main doors as the building was next to a busy dual carriage way and so, for the safety of children, this door needed to be manually opened. The front doors to the practice were to be replaced with power assisted doors by end of March 2015 to improve access for people with disabilities and patients with children in pushchairs.

There was a hearing loop at the reception desk for patients with impaired hearing and four high back chairs with arm rests were provided to assist patients with mobility problems.

Fact sheets were available in different languages on the practice website to explain the role of UK health services and the National Health Service (NHS), to newly-arrived individuals seeking asylum. They covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services. The web site also had a translate page function so patients could view the whole website in a language of their choice.

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. This indicated the patients were generally satisfied with the appointments system at the practice. For example, 76% of respondents described their experience of making an appointment as good compared to the local (CCG) average of 65%.

Some patients we spoke with told us they had difficulty getting through to the practice by phone to make an appointment. However, 73% of respondents to the national patient survey said they found it easy to get through; the local CCG average was 71%. The reception staff told us there were only two lines for all calls into the practice. Patients said there was no on hold function or queuing system and they had to just keep trying.

The practice had reviewed its appointment system in response to concerns from patients and results of PPG surveys about the lack of appointments available to them. They had reduced the number of pre-bookable appointments but increased the number of routine "book on the day" type appointments. They had also introduced a "quick clinic" each day for more minor problems and issues that only needed a 5 minute review. Patients told us they had seen an improvement in the access to appointments

Good

Are services responsive to people's needs?

(for example, to feedback?)

and they could get an appointment for urgent care on the same day. The patients said they could request to see a named GP although one person told us they had to insist that was the person they wanted to see before being offered an appointment.

Reception staff told us some appointments were pre-bookable and some had been allocated for booking on the same day and for patients to book online. We observed there were appointments available on the day of the inspection and pre-bookable appointments were available for the following day. Extended hours appointments were available four mornings per week from 7am to 8am. The times of the extended hour's appointments had been decided following consultation with the PPG. Patients who worked told us these times were very useful for them.

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

Home visits were made to local nursing homes as required and to those patients who needed one.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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.

We saw that information was available to help patients understand the complaints system on the web site and a complaints information leaflet was available from reception. Guidance on raising concerns was displayed in the practice but this did not include information about the formal complaints process. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at how complaints received by the practice in the last 12 months had been managed. We saw 13 complaints had been received. The records showed complaints had been dealt with in a timely way and patients had received a response which detailed the outcomes of the investigations. We also saw an apology had been given to patients where appropriate and information on how to escalate their complaint if they were not satisfied with the response.

We found from records and discussions with staff learning from complaints had been shared with them.

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 had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had developed a statement of purpose which included their aims and objectives and a summary of these were displayed on the practice website. The practice aims and objectives included the aim to offer the highest standard of health care and advice to patients, staff and third party stakeholders with the resources available to them.

Our discussions with staff and patients indicated the vison and values were embedded within the culture of the practice. Staff told us the practice was patient focused and they told us the staff group were well supported.

Governance arrangements

We found there was a well-established management structure with clear allocation of responsibilities and all the staff we spoke with understood their role. We found the senior management team and staff continually looked to improve the service being offered. All the staff we spoke with felt the practice delivered a high quality of service. Regular meetings were undertaken including regular partners, staff and multidisciplinary meetings.

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 GP partner was the lead for safeguarding and another GP was the lead for information governance. The staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw there were clearly thought through information governance procedures in place. We observed adherence to the procedures by all the staff. We saw the information governance lead had completed an audit of the information governance procedures and had made improvements to the procedures for destruction of confidential waste. They had also identified an issue with an external agency and referred this back to them for action.

The lead GP and practice manager had a clear vison for the practice and a business plan and development plan was in place. Annual meetings were held for clinicians and managers to discuss these plans. Minutes of meetings were maintained but these did not always identify who had responsibility for completing any required action and dates for completion were not identified. A financial review of the practice had not been completed and a financial plan for the future had not been developed.

The practice had a number of policies and procedures in place to govern activity and these were available to staff. The policies had been reviewed but a record of who had reviewed the policies and when the review had taken place had not always been recorded.

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 or above national standards and the practice had achieved almost maximum QOF points at 99.5%. We saw QOF data was regularly discussed and evaluated at monthly team meetings.

The practice had an ongoing programme of clinical audits which were used to monitor quality and to identify where action should be taken. The GPs clinical audits were often linked to medicines management information or as a result of information from incidents. We saw monthly audits of antibiotic prescribing trends and improvements to GP prescribing practice had been made as a result of these. The practice recognised they could expand their audit process and include more in-house audits to monitor the quality of the service.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented. However, we saw that risks for staff who worked alone had not been assessed.

Leadership, openness and transparency

The staff told us there was a relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues.

The practice held regular staff meetings. We looked at the minutes from the last two meetings and found performance, quality and risks had been discussed.

We saw from minutes that team meetings were held regularly, at least monthly and clinical meetings were held every week. The staff told us there was an open culture within the practice. The majority said they had the

Are services well-led?

Good

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

opportunity and were happy to raise issues at team meetings. Some staff felt they were not as involved with the development of the practice as they would like to be. They told us they were not invited to the annual away day. One staff member told us they seemed to miss out on meetings for clinical or administration staff as their role didn't seem to fit either category.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The majority of patient feedback we reviewed was positive.

The practice had an active patient participation group (PPG) comprising of 41 members. The group was a "virtual group", which meant most members participated online. So as to not exclude those without internet access they also allowed members to participate by post, providing stamped addressed envelopes for them to send surveys back.

The PPG included representatives from various population groups but with the majority being from patients of the working age group. Patients under 16 year of age and those over 75 years were not represented on the group. The practice had identified the group was under representative of ethnic minority groups and were actively trying to recruit patients from this demographic group. The practice advertised the PPG extensively in the practice and on the website. They told us they had, at times, also advertised in local businesses and once or twice a year advertised in the local paper which was delivered to every household within the practice area. All new patients were invited to join the PPG.

The PPG had been involved in planning the annual surveys, reviewing the feedback and agreeing the action plan. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website and were posted to the postal members. We spoke with a PPG representative following the inspection. They told us the practice worked well with them and listened to their suggestions. They told us the practice were implementing the agreed action plan following the last survey and as part of this had provided the information screen in reception. They also said they received feedback following meetings and were kept up to date by email.

Staff feedback was gathered at regular practice meetings and through annual appraisals. Staff told us they felt comfortable approaching any of the management team.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had been able to develop their skills and knowledge.

The practice had completed reviews of significant events and other incidents and shared the information with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw that where there had been a failure in recording a diagnosis on patients records the procedures had been reviewed and changed to ensure that the risk of reoccurrence was minimised.