

Thornton Medical Centre

Quality Report

Thornton Medical Centre
4 Craven Avenue
Thornton
BD13 3LG
Tel: 01274 832110
Website: www.thorntondenholmmedicalpractice.nhs.uk

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice:

We carried out an announced inspection visit on 03 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:

- The practice learned from significant events and incidents and took action to prevent their recurrence.
- All areas of the practice were visibly clean.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to help ensure they were up to date with best practice.
- The service was responsive and ensured patients received accessible, individual care, whilst respecting their needs and wishes.

- There were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice including:

- The practice was piloting 'The Gold Line Service.' Patients who were on the palliative care register were given a telephone number with direct access to palliative care nurses, 24 hours a day.
- The practice is taking part in the Bradford's Healthy Hearts campaign, initiated by the NHS Bradford Districts Clinical Commissioning Group (CCG). It is aimed at reducing the risk of stroke and heart attack in people who were in risk groups.
- The practice was an accredited level 2 Diabetes practice. This meant patients had a service local to them and also had access to a dietitian.

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?

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.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with national standards. 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.

Good



Are services caring?

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, 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.

Good



Are services responsive to people's needs?

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 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.

Good



Summary of findings

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 it 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

The practice is rated as good for the care of older patients. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in end of life care. They were responsive to the needs of older people, and offered home visits to patients who were housebound.

Good



People with long term conditions

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. This helped to offer the patient a better overall experience when meeting their needs. The practice was an accredited level 2 Diabetes practice. This meant patients had a service local to them and also had access to a dietician.

Healthcare professionals were skilled in specialist areas and their ongoing education meant they were able to ensure best practice was being followed. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

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 immunisation and maternity services. There was health education information relating to these areas in the practice to keep people informed. Appointments were available with practice nurses and GP outside of school hours.

Good



Working age people (including those recently retired and students)

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. A full range of health promotion and screening clinics were available; these reflected the needs of this population group.

Good



Summary of findings

People whose circumstances may make them vulnerable

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. These patients received an annual health check and longer appointments were available where required. Access to translation services were available when needed.

Good



People experiencing poor mental health (including people with dementia)

The practice provided care for people experiencing a mental health problem, including those patients with dementia; which was safe, caring, responsive and effective. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Good



Summary of findings

What people who use the service say

We received 23 completed patient CQC comment cards where patients shared their views and experiences of the service. We also spoke with three patients on the day of our inspection.

Patients told us and comments from the CQC comment cards said: the service was good, and the environment was clean and safe. They said the staff were helpful, respectful, supportive of their needs and in decisions about their care. They were kept informed and received a caring service.

With the exception of one patient who sometimes experienced difficulty in booking an appointment with a

doctor of their choice, other patients reported the service was good. They said staff always tried to accommodate them when making an appointment and if one was not available, an alternative would be offered.

Responses to the NHS patient survey identified: The GP and nurses were good or very good at treating patients with care and concern; patients described the overall experience of their GP surgery as fairly good or very good. However patients said they could not always see or speak to the GP they preferred and they were not always happy with their GP practice opening times.

Outstanding practice

- The practice was piloting 'The Gold Line Service.' Patients who were on the palliative care register were given a telephone number with direct access to palliative care nurses, 24 hours a day.
- The practice is taking part in the Bradford's Healthy Hearts campaign, initiated by the NHS Bradford Districts Clinical Commissioning Group (CCG). It is aimed at reducing the risk of stroke and heart attack in people who are in risk groups.
- The practice was an accredited level 2 Diabetes practice. This meant patients had a service local to them and also had access to a dietitian.

Thornton 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 SPA GP, practice manager, and an observer from the Department of Health.

Background to Thornton Medical Centre

Thornton Medical Centre has a main surgery at Craven Avenue, Thornton, Bradford and a branch surgery at Denholme, in Bradford. The branch surgery was not visited on this occasion.

The practice has two general practitioner (GP) partners, both female and the practice manager is also a partner and registered manager. There are five salaried GPs, two male and five female. The practice was accredited as a GP Training Practice 18 months ago.

Working alongside the GPs is an advanced nurse practitioner, a nurse practitioner, two practice nurses, a health care assistant (all female,) and a pharmacist. There is an experienced management team including, patient services manager, and administration/reception staff.

The company that holds the Thornton and Denholme practice contract is Westcliffe Care UK Ltd. The practice is part of the 'Westcliffe Group' of five practices and they share human resource (HR), governance, quality and management functions, including strategic planning for service delivery.

The practice has an Alternative Provider Medical Services (APMS) contract. APMS provides the opportunity for locally

negotiated contracts with non-NHS bodies, such as voluntary or commercial sector providers, to supply enhanced and additional primary medical services. Their registered list of patients is 8,333.

The main practice opening times are Monday 7.30am to 7pm, Tuesday 7.30am to 6pm, Wednesday, and Thursday, Friday 8.30am to 6pm, and Saturday mornings (pre booked appointments only), 8.30am to 11am, with the exception of the last Saturday in the month. The branch surgery has specific opening times to meet the local needs and these are Monday 8.30am to 7pm, Tuesday and Wednesday 8.30am to 5pm, and Friday 8.30am to 1pm, Thursday 8.30am to 12md, and the last Saturday in the month, 8.30am to 11am.

When the practice is closed patient calls will automatically be transferred to the Out of Hours service or they can telephone 111 direct for care and advice.

A range of services are available at the practice and these include: vaccinations and immunisations, 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.

Detailed findings

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held 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 03 February 2015. During our inspection we spoke with staff including two GPs, an advanced nurse practitioner, practice pharmacist, practice manager, patient services manager, and administration/reception staff.

We spoke with three patients who used the service; observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 23 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

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. This showed the practice demonstrate a safe track record over the long term.

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 where appropriate.

Learning and improvement from safety incidents:

We saw there was a Critical Incident Reporting policy dated May 2014, with a review date of May 2015. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed incident reports and minutes of the managers and clinicians meetings where these were discussed. Other staff were made aware of these where appropriate. Following the inspection we were also sent a copy of an incident log which had been discussed at a meeting and held separately to the minutes. The information was held electronically for all staff to see. We saw the log contained the incident, what had happened and why, learning taken place and what the practice had changed to prevent recurrence. Staff were also able to tell us examples of incidents, learning taken place and measures taken to help prevent recurrence.

Reliable safety systems and processes including safeguarding:

There were policies and protocols for safeguarding vulnerable adults and children. Staff had received training relevant to their role and this included safeguarding vulnerable adults and children training. We asked members of medical, nursing and administrative staff about their most recent training. They knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities, how to contact the relevant agencies and contact details were easily accessible.

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 identified and reviewed. Records and minutes of meetings demonstrated, there was frequent liaison with partner agencies such as, health visitors and social services.

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 when chaperones were needed the role was carried out by non clinical staff who had received training. Following the inspection we received the chaperone policy, dated January 2015. The policy identified individual staff who had received the chaperone training. It clearly stated chaperones would never be left alone, and should the clinician leave the examination room, the chaperone must also leave the room. The policy also stated, the chaperone who accompanied the clinician at the time of the examination was to be recorded in the patient's notes.

Medicines management:

We saw emergency equipment was available in the surgery which included emergency medicines. The practice had arrangements for managing medicines to keep patients safe. Staff were aware of the protocols for the accessibility of emergency drugs, and the action of individual staff (for example, administrative staff) in an emergency situation.

Requests for repeat prescriptions were taken online, via the local pharmacy or at the reception desk, and for housebound patients, by telephone. 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.

The practice employed a pharmacist. They assisted with monitoring the practice performance towards key prescribing indicators (KPI) and they completed medication audits. For example, where alerts were received about medicines the pharmacist conducted an audit of patients who received the medicine and the GP then reviewed this to establish if any changes were required. The

Are services safe?

pharmacist also completed ongoing audits of antibiotic prescribing practice and clinical staff were informed of the outcomes at meetings. They told us they had seen improvements in antibiotic prescribing practice since they used this system.

Cleanliness and infection control:

We observed the premises to be clean and tidy. Cleaners were employed by the practice and monitoring of the cleaning took place. Patients we spoke with told us they always found the practices clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control and records showed all staff had up to date infection control training. We saw an infection control audit had taken place and the practice had scored 83%.

An infection control policy and supporting procedures were available for staff to refer and these included needle stick injury.

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.

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. We saw evidence of calibration of relevant equipment had taken place in January 2015.

Staffing and recruitment:

We saw there was a recruitment procedure dated March 2014 and a record showing the checks carried out prior to employment. This included proof of identification, two references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

We saw an audit had taken place to ensure there were sufficient staff in relation to the development of an intra-uterine coil fitting service. The audit had been looked at in relation to National guidance, and the practice had been looking at how to address any shortfalls.

We saw there were changes in progress in relation to the organisational structure for administration and management staff due to the coming together of the practices in the group, this included centralising some functions. Staff felt well supported and had been informed of the changes.

Monitoring safety and responding to risk:

All staff had risk management training. We saw risk assessments were in place and had been reviewed in April 2014. 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 and infection control. 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. Staff told us safety alerts were discussed at the clinicians meetings where the information was reinforced.

Health and safety posters were in staff areas and all staff had received up to date training.

Arrangements to deal with emergencies and major incidents:

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice had a contract with a company who replaced the emergency medicines when they were due to expire. All the medicines we checked were in date and fit for use.

Management plans were in place to deal with the smooth running of the practice and 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 were told by the reception/administration staff that each day they printed

Are services safe?

out the GP and nurse's patient lists for the following day. By doing this, they would be able to maintain a service for patients in the event the computer system was not available to access the patient lists.

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 diabetes. 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.

The practice held multiple clinic appointments where appropriate, such as for those patients who had more than one long term condition. All new patients received a health check with the health care assistant and where concerns were identified they would be followed up by a GP.

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. Additionally palliative care meetings were held and they included other professionals involved in the individual patient's care.

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. There were additional services available at the practice and these included Smoking Cessation Advice & Support. Health promotion literature was also available and visible in the practice waiting areas and was brought to patients' attention through the practice website.

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 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 all patients in need of palliative care/support irrespective of age, when compared to other practices in the CCG area.

Effective staffing:

Practice staffing included medical, nursing, managerial and administrative staff. We noted a good skill mix among the staff. GPs all had additional interests such as cardiology, dermatology, and maternal health. Two of the GPs we spoke with told us they were up to date with their continuing professional development requirements and had been revalidated in the last two years. Additionally one of the GPs told us they had one week study leave a year and this had been included in their contract. (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).

The practice was accredited as a GP Training Practice 18 months ago and one of the GPs was a GP trainer. There was a 'locum pack' containing local protocols, procedure and guidance for trainees, locums and new staff to follow.

The practice ensured all staff kept up to date with both mandatory and non-mandatory training. We saw the training matrix for 2014/2015 and the information showed staff attended training such as information governance, equality and diversity, health and safety, fire safety, infection control and basic life support. On the day of inspection, the training matrix did not contain actual dates

Are services effective?

(for example, treatment is effective)

training had taken place. Following the inspection we were provided with this information and evidence the staff were up to date with their training. (This included level three safeguarding training for the clinicians.)

Staff told us they received appraisals and this included a personal development plan. We reviewed five appraisal records and noted two of the appraisals had not taken place annually. Following the inspection we were provided with a full list of staff who worked at the practice. The information included the date when each individual was due their next annual appraisal, ranging from May 2015 to February 2016.

We were told new staff were provided with induction training and were monitored during their first few weeks in post. They were able to access relevant up to date policy documents, procedures and guidance.

However, although staff told us they were supported in their role and had received an induction, not all documentation inspected had been signed to show it had been completed. Following the inspection we were provided with copies of the induction records, of the last two staff appointed by the practice. The records showed each member of staff and their manager had signed the documentation to show their induction had been completed.

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.

One of the GPs was the lead for End of Life Care (EOLC). They had monthly Gold Standard Framework (GSF) meeting to discuss patients on this register and help to ensure their needs were being consistently met. We saw the care plans for these patients were comprehensive and included the treatment, care and support to meet their needs.

We were also told the practice was piloting 'The Gold Line Service.' Patients who were on the palliative care register were given a telephone number with direct access to palliative care nurses, 24 hours a day. This meant these patients received the support they needed and avoided inappropriate admissions to hospital.

Another of the GPs had a special interest in cardiology and worked at the hospital in this area. We were told they shared ideas with the practice to improve services for patients. For example, those patients who had atrial fibrillation. The GP also acted as a resource in this area of expertise for the practice GPs.

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 used a computer system to store patient records. Staff input data such as discharge letters and blood results into the electronic records. Tasks were then sent electronically for the GP to review the information and action as appropriate. Patients when visiting the clinic for any test were advised when to telephone for the result and where appropriate, a follow up appointment would be made with the GP.

Information sharing:

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 the multi-disciplinary team within the locality. These included palliative care nurses, health visitors, community matron, and district nurses. There were also regular informal discussions with these staff. This helped to share important information about patients including those who were most vulnerable and high risk.

Systems were in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). We were told by a GP, the GPs sent the administration staff a task through the computer system and the staff then helped make the patient appointment.

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

Are services effective?

(for example, treatment is effective)

used to check whether these patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Patients felt they could make an informed decision. They confirmed their consent was always sought and obtained before any examinations were carried out. Patients told us they were aware chaperones were available however they had not had to use one.

Health promotion and prevention:

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

The practice was taking part in the Bradford's Healthy Hearts campaign, initiated by the NHS Bradford Districts Clinical Commissioning Group (CCG). It was to be developed over three year and aimed at improving the care of patients with heart disease and raise awareness of heart health. As a result, patients can expect a more detailed assessment by their GPs and their treatment adjusted where necessary.

The practice was promoting a system for the monitoring of patients with a Long Term Condition (LTC), such as diabetes, high blood pressure, chronic chest trouble or

heart failure. We saw the information asked patients if they would like to be involved in trialling a product which would help them look after themselves more effectively. The system linked to the computerised system used at the practice and displayed patient information for their GP to monitor. The information also stated, it allowed patients together with their GP to monitor their success through personal goal setting and achievements, and delivering personalised care.

The practice had Practice Health Champions working with them to improve the health and wellbeing of patients. This service was funded by a group of organisations including the Bradford CCGs. The practice GPs and staff had met with the group in support of this initiative. We saw meeting minutes of when the group met in December 2014 and February 2015. They showed the topics discussed included, crime prevention and keeping safe, pharmacy involvement at a practice health event, and arranging walks.

The practice web site directed patients to information about 'Self-treatment of common ailments;' and promoted information about how to become healthy. A range of health information leaflets were also displayed in the practice waiting area. Additional services were available for patients within the practice, for example Smoking Cessation Advice & Support Clinic. This had the benefit of providing local, accessible services for patients.

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 kindness, dignity, respect and compassion whilst they received care and treatment.

The practice had a chaperone procedure in place to support patients and there was information about this on their web site. Signs were also displayed in the practice explaining the chaperone policy. The chaperones could be a family member, or friend or a trained member of staff. Staff who acted as chaperones had all undergone training provided by an external company. Staff confirmed they accompanied the clinicians and were not left alone with a patient when carrying out chaperone duties.

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 well-being 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. We also saw the practice web site gave guidance to patients about the steps they should take following a death.

Comments on the CQC patient comments cards stated, staff were pleasant, helpful, caring and understanding when they needed help; 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.

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 patients' 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 regularly sought the views of patients through the patient survey, and the Patient Participation Group (PPG).

Tackling inequity and promoting equality:

The practice had extended opening hours on a Monday 7.30 am to 7 pm, Tuesday 7.30 am to 6 pm and the last Saturday in the month (pre-booked appointments only), 8.30 am to 11 am. This had allowed for flexible access for patients including working age patients and those in full time education. We were also told by staff, the changes had improved the availability and access to appointments for both GP's and nurses.

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. For example, those patients who have a learning disability or patients experiencing poor mental health, including those with dementia.

We were told the practice nurses carried out immunisations and vaccination, and this role was also carried out by district nurses on occasions.

Meetings with the health visitor took place four to six weekly. Children who were vulnerable and at risk were discussed together with patients who had not attended for child health appointments. This identified those patients who may need to be followed up by the health visitor.

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.

Patients with a long term condition such as asthma and diabetes, had care plans in place and this included those who were at risk of re-admission to hospital. These were shared with the patient and helped offer the patient a better overall experience in meeting their needs.

The practice was an accredited level 2 Diabetes practice. This meant patients had a service local to them and also had access to a dietician.

Healthcare professionals were skilled in specialist areas and their on-going education supported them to follow best practice guidelines.

Access to the service:

Information was available to patients about appointments in the practice's waiting room and on their website. Appointments could be booked on the day or up to eight weeks in advance to see the GP or nurse; via telephone, on-line or in person. Telephone consultations were also available, and an on-call GP for urgent appointments which needed to be dealt with on the day. Home visits were also available for patients who were housebound because of their illness or disability.

The main practice opening times were Monday 7.30am to 7pm, Tuesday 7.30am to 6pm, Wednesday, and Thursday, Friday 8.30am to 6pm, and Saturday mornings (pre booked appointments only), 8.30am to 11am, with the exception of the last Saturday in the month. The branch surgery had specific opening times to meet the local needs and those were Monday 8.30am to 7pm, Tuesday and Wednesday 8.30am to 5pm, and Friday 8.30am to 1pm, Thursday 8.30am to 12md, and the last Saturday in the month, 8.30am to 11am for pre bookable appointments.

When the practice was closed patient calls were automatically transferred to the Out of Hours service or they could telephone 111 direct for care and advice.

Listening and learning from concerns and complaints:

The practice had a system in place for handling complaints and concerns. At the time of the visit the complaints procedure was not available on reception. This was brought to the attention of the reception staff and the complaint information was made available. Staff were aware of the procedure for complaints and this was in line with recognised guidance and contractual obligations for GPs in England.

We saw information was available on the practice web site to help patients understand the procedure if they had a comment or suggestion, or they wished to complain.

We were told the patient service manager had an open door policy for staff and patients, so concerns or

Are services responsive to people's needs? (for example, to feedback?)

complaints could be responded to in a timely manner. We saw a log of complaints received and noted the action taken and lessons learnt had been recorded. We noted where appropriate, the information had stated the incident was discussed at the management team meeting. We were told the outcomes of complaints, actions required and lessons learned were shared with staff where appropriate, and staff we spoke with confirmed this.

Patients we spoke with were happy with the care they received at the practice and they knew how to make a complaint should they need to. They also felt they would be listened to.

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 vision to deliver high quality care and patient focused care. The practice manager, GPs and staff were clear about their roles and responsibilities and the vision of the practice. They worked closely with the local CCG and were committed to the delivery of a high standard of service and patient care.

Governance arrangements:

The practice was working together with three other practices within the group and was developing shared governance functions such as, human resources. We found the organisational management structure was going through a period of change and although the managers were clear about the plans and changes taking place, they continued to recruit into senior roles within the organisation.

Whilst the GPs and practice manager we spoke with had a clear vision for the practice and investments had taken place, on the day of the inspection the business plan was not available to see. We were told by staff this had been discussed as a team and the business plan would be circulated when completed in written form.

The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. For example, we saw there was a return to work procedure, recruitment and selection procedure dated January 2015, and with a review date of January 2016.

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 by having regular palliative care meetings, maintaining a register of patient needing palliative care, and those over 18 years of age with a learning disability.

The practice had evidence of clinical audits which were used to monitor quality, identify where action should be taken and help to improve outcomes for patients. We were told by GPs they each did an annual audit. For example one GP had done an audit on 'The assessment of atrial

fibrillation patients taking warfarin.' We saw the audit had taken place in March 2014 and re-audited in September 2014. The information showed the conclusions and learning which had taken place.

Leadership, openness and transparency:

There was a clear leadership structure within the practice and named members of staff in lead clinical roles. For example, lead GPs for safeguarding, End of Life Care (EOLC) and diabetes. All staff we spoke with were clear about their own roles and responsibilities.

Staff we spoke with told us all members of the management team were approachable, supportive, appreciative of their work, and knew who to go to in the practice with any concerns. The practice had a whistleblowing policy which was available to all staff. A staff member we spoke with told us they were aware of the policy but had not read it.

The practice had a proactive approach to incident reporting, and staff told us there was a 'no blame culture'. Meetings were held with clinicians and managers where incidents were discussed 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 in meeting patient's needs.

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

The practice had gathered feedback from patients through the Patient Participation Group (PPG), Practice Health Champion meetings, practice and NHS patient surveys, and complaints received.

We looked at the results of the annual patient survey which were displayed in the practice's waiting room. 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 provide a photograph notice board of all GPs, their specialties and working schedule and publish it on their web site. We saw action had been taken. A notice board had been placed in reception with the information requested, and the information had been included on the practice web site. As a result of patient feedback we also saw the signage on the consulting room doors had been made more visible in large print.

Are services well-led?

Good 

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

Responses to the NHS patient survey identified: The GP and nurses were good or very good at treating patients with care and concern; patients described the overall experience of their GP surgery as fairly good or very good. However patients said they could not always see or speak to the GP they preferred and they were not always happy with their GP practice opening times. Following this the practice had extended their opening hours and this included a Saturday morning surgery.

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.

The PPG was made up of six to eight patients and contact was either by email or face to face. We saw information on the practice web site advertising for patients to join the group; this was with a view to sharing their experiences and

suggestion to improve the service. We also saw minutes of meeting, and a report on the progress, participation, outcomes and information relating to developing and maintaining the PPG.

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. This included update training such as diabetes care. The advanced nurse practitioner also told us learning was carried out through their weekly clinical meetings. They gave an example, where they had done a presentation on asthma and Chronic Obstructive Pulmonary Disease (COPD), and said it had been well received.

We were told the practice staff learnt together with the other GP practices in the group. They worked together to resolve problems and learn and share information to proactively improve the quality of services.