Dr Majid Azeb

Quality Report

Southowram Surgery
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Date of inspection visit: 8 April 2015
Date of publication: 09/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Majid Azeb (Southowram Surgery) on 8 April 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

Our key findings were as follows:

- Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day.
- 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 were involved in care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints were addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients.
- Risks to patients were assessed and well managed.
- The practice had a number of policies and procedures in place and held regular governance meetings.
- The practice had good systems in place to ensure regular and prompt follow up for patients believed to be in circumstances that made them vulnerable or at risk.

We saw the following areas of outstanding practice:

Summary of findings

- The practice manager and health care assistant had trained to be a Dementia Friend and could provide additional support to patients, carers and other practice staff as the need arose.
- The practice had good follow up care for the families of bereaved patients. A sympathy card was sent and an appointment for bereavement support was offered.

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. There were enough staff to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were effective processes in place for safe medicines management.

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 the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of annual appraisals and staff had received training appropriate to their roles. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of their care. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Care planning templates were available for staff to use during consultation. Information to help patients understand the services was available and easy to understand. We saw staff treated patients with kindness, respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Calderdale Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available both in the practice and on the website. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy and staff were clear about their roles and 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 in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff received induction, regular performance reviews and attended staff meetings. The practice proactively sought feedback from patients and staff which it acted upon. The Patient Participation Group (PPG) was active and the practice engaged with them on a regular basis.

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 that outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP and were offered an annual health check. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice worked closely with other health care professionals, such as the district nursing team and community matron, to ensure housebound patients received the care they needed. Patients 75 and over who were socially isolated and felt lonely were signposted to the local Staying Well Ageing Better service, which specifically targeted loneliness in the elderly.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice had a GP led approach to long term conditions, supported by the nursing staff. There were structured annual reviews in place to check the health and medications needs of patients were being met. Longer appointments and home visits were available when needed. Staff worked with relevant health and social care professionals to deliver a multidisciplinary package of care. For example, newly diagnosed patients with diabetes were referred to specialist diabetic support services such as DESMOND. This is a programme of self-management and education for people who are diagnosed with type 2 diabetes.

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. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Children between the ages of two and four were offered the nasal spray vaccine in line with the seasonal influenza programme. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice told us all young children were prioritised and the under-fives were seen on the same day as requested.

Summary of findings

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 practice had extended hours, including pre-bookable early morning appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. For example, patients who would benefit from social engagement and were aged 50 and over were signposted to a local service known as SOFA (Southowram over fifties). All new patients aged 16 years or over were offered a health check. The practice also offered urgent care for patients who worked or studied away from home (out of area registrations).

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 and offered longer appointments for people with a learning disability. The practice maintained a carers' register and those patients were also offered an annual health check.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They 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. Any patients who were identified as being vulnerable, including looked after children and people who were homeless, were read coded on the practice electronic system. An electronic search was undertaken on a monthly basis to identify whether patients within these cohorts were attending appointments. If found to not be attending their appointment they were subsequently followed up by the practice. The practice had good systems in place to ensure regular and prompt follow up for patients, believed to be in circumstances that made them vulnerable or at risk.

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. The practice offered annual health reviews, longer appointments and home visits as needed for all patients who had poor mental health or dementia. The GPs actively screened patients for dementia and maintained a list of those diagnosed. Both the practice manager and health care assistant had trained to be a Dementia Friend. The practice regularly worked with multidisciplinary teams in the case management of

people in this population group. For example, the local mental health team. Information was readily available through the practice advising patients how to access various support groups and voluntary organisations.	

Summary of findings

What people who use the service say

We spoke with five patients and a member of the patient participation group (PPG) on the day of our visit. We observed patients had a significantly short waiting period from the time of their appointment to the clinician seeing them. The majority of patients we spoke with told us appointments 'ran on time', they 'didn't feel rushed' during the consultation and they received a 'great service'. They told us all staff were polite and approachable and they were treated with dignity and respect at all times.

We received 42 CQC comment cards which patients had used to record their experience of the service they received from the practice. All the comments were very positive and complimentary about the practice and the staff. Many patients commented specifically on the care and treatment they had received by all the GPs in the practice, describing them as 'extremely helpful' 'fantastic' and 'amazing'. They told us the clinicians listened to them, explained treatments and involved them in decisions about their care.

A member of the PPG told us the practice was proactive in supporting the group and had acted on issues that had been raised. For example, the practice had altered how the chairs in the waiting room were placed to allow for easier wheelchair and pushchair access in that area.

We looked at the National Patient Survey (January 2015), which had sent out 229 surveys and received 114 responses (an almost 50% completion rate). Ninety seven per cent of respondents rated their overall experience of the practice as 'very or fairly good', compared to the CCG average of 85%.

The results showed the practice to be above average for the CCG in many areas. For example, 94% of respondents found the receptionists at the surgery helpful (CCG 85%) and 90% were satisfied with the surgery's opening hours (CCG 73%).

Outstanding practice

We saw the following areas of outstanding practice:

- The practice manager and health care assistant had trained to be a Dementia Friend and could provide additional support to patients, carers and other practice staff as the need arose.
- The practice had good follow up care for the families of bereaved patients. A sympathy card was sent and an appointment for bereavement support was offered.

Dr Majid Azeb

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 specialist advisor and a practice manager specialist advisor.

Background to Dr Majid Azeb

Dr Majid Azeb operates from Southowram Surgery based within the outskirts of Halifax. The practice provides Personal Medical Services (PMS) under a contract with NHS England. It serves a population of approximately 2761 patients who are predominantly English speaking and from different socio-economic backgrounds.

There is one male and one female GP at the practice who are supported by a practice nurse and a health care assistant. The practice has an experienced administration team, consisting of a practice manager and three receptionists.

Dr Azeb is a GP trainer and honorary lecturer at the University of Leeds, as well as a governing body member of Calderdale Clinical Commissioning Group (CCG) and a member of the Local Medical Committee (LMC).

Southowram Surgery offers a range of appointments between 8.30am and 6.30pm every weekday. It has extended hours from 6.30pm to 7.45pm on Mondays. When the practice is closed out of hours cover is provided by Local Care Direct and the NHS 111 service.

A wide range of services are available at the practice which include vaccinations and immunisations, cervical screening, child health surveillance and management of long term conditions. For example, asthma, chronic obstructive pulmonary disease (COPD) and diabetes.

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

Please note 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 CQC at that time.

How we carried out this inspection

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

We carried out an announced inspection at Southowram Surgery on the 8 April 2015. During our visit we spoke with a range of staff, including two GPs, the practice manager, two receptionists and the practice nurse. We also spoke with five patients who used the service and a member of the patient participation group (PPG).

We observed communication and interactions between staff and patients; both face to face and on the telephone

Detailed findings

within the reception area. We reviewed 42 CQC comment cards where patients had shared their views and experiences of the practice. We also reviewed documents relating to the management of the practice.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

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, comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We reviewed safety records, incident reports and saw evidence in minutes of clinical meetings where these were discussed. This showed the practice had managed these consistently and could demonstrate a safe track record over the long term.

Learning and improvement from safety incidents

There were systems in place for how the practice managed safety alerts, significant events, incidents and accidents. Significant event analysis was a standing agenda item on the weekly clinical meetings. They were also discussed at the monthly practice meeting. Some administration staff told us they could not always attend the monthly meetings but were aware of what incidents had taken place and the actions taken. Staff we spoke with confirmed there was an open and transparent culture. They knew how to raise issues for discussion and were encouraged to do so.

The practice manager showed us the electronic reporting system the practice used to record, manage and monitor all clinical and non-clinical incidents. We looked at three records of reported incidents and saw they had been completed in a comprehensive and timely manner. They included learning points or improvement actions. We looked at one significant event in detail where a referral had been made to secondary care but the patient had not received an appointment. When the practice looked at this it was confirmed a faxed referral had been sent but they were told it had not been received at the other end. As a result the practice amended their protocols to confirm all faxed referrals were received.

Where patients had been affected by something that had gone wrong we saw, where applicable, action had been taken to protect patients' 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 relevant role specific training on safeguarding. Staff we spoke with were aware of their responsibilities and knew how to share information, record safeguarding concerns and how to contact the relevant agencies in both working hours and out of hours. Safeguarding policies, procedures and the contact details of relevant agencies were available and easily accessible for all staff.

The practice had a designated GP lead in safeguarding vulnerable adults and children, who had completed level 3 safeguarding training. All staff we spoke with were aware of who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system in place to highlight vulnerable patients on the practice's electronic record. The practice held a monthly multidisciplinary meeting with other professionals, such as the health visitor, to discuss concerns and share information about children and vulnerable patients registered at the practice.

An electronic search was undertaken on a monthly basis to identify whether vulnerable and at risk patients were attending appointments. If found to be not attending their appointment they were followed up by the practice.

There was a chaperone policy in place and notices displayed in the reception area highlighting the availability of a chaperone if required. Reception staff acted in the capacity of chaperone and had appropriate checks through the disclosure and barring service (DBS). They had received up to date chaperone training and could explain what their roles and responsibilities were. 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. We were told if a patient required a chaperone, the GP would send a notification to the admin team via the practice computer system. The GP also recorded the presence of a chaperone in the patient's record.

Medicines management

We checked medicines stored in the treatment rooms and found they were stored securely and only accessible to authorised staff. We checked the refrigerators where vaccines were stored. Staff told us the procedure was to check the temperatures on a daily basis and record it. We saw evidence of daily records being kept which were dated,

had the temperature recorded and had been signed by a member of staff. We were told vaccines were checked for expiry dates on a monthly basis and disposed of in line with the practice protocol. We looked at a selection of vaccines and found they were within their expiry date. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a repeat prescribing protocol in place. Requests for repeat prescriptions were taken in person at the reception desk, over the telephone, by post or online via the practice website. We were informed about checks that were made to ensure the correct patient was given the correct prescription. All prescriptions were reviewed and signed by a GP before they were issued to the patient. The practice was also piloting electronic prescribing where some patients could order their prescriptions and have them delivered direct to a pharmacy of their choice.

There were procedures in place for GP annual reviews and monitoring of patients who took regular long term medication. When the penultimate prescription had been issued, a task was generated via the computer system for the GP to undertake a review and initiate any appropriate blood tests prior to any further prescriptions being processed.

The data from Calderdale CCG which related to the practice's performance for antibiotic prescribing showed them to be comparable to similar practices.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice. All prescription forms were kept in a cupboard within a locked room which was only accessed by authorised staff.

Cleanliness and infection control

We found the premises to be clean and tidy. We saw there were cleaning schedules in place and records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

There was a policy in place for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records confirmed the practice carried out checks in line with this policy. The last assessment had been completed in March 2013. It identified the practice did not pose any threat to legionella as no standing water is held on the premises.

An infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment (PPE) including disposable gloves and aprons were available for staff to use. Hand washing sinks with hand soap, antibacterial gel and hand towel dispensers were available in treatment rooms. Sharps bins were appropriately located and labelled. The practice had access to spillage kits and staff told us how they would respond to blood and body fluid spillages in accordance with current guidance. There was a nominated lead for IPC who could support staff regarding any infection control issues.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw there was a schedule in place to ensure all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested. The sample of equipment we inspected had up to date Portable Appliance Tests (PAT) stickers displaying the last testing date. We saw evidence of calibration of equipment where required, for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice used a recruitment consultancy service with regard to recruitment policies and procedures. The practice followed these when recruiting clinical and non-clinical staff. The practice had a small number of staff with very little turnover. The newest member of staff had been the practice manager. We saw evidence that appropriate recruitment checks had been undertaken prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number and mix of staff required by the practice to meet the needs of patients. There was an arrangement in place for members of staff, this included

Good

Are services safe?

clinical and non-clinical, to cover each other's annual leave and sickness. They 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 were told the practice used locums only in exceptional circumstances. The GPs had a buddy system and would do extra sessions to cover for holidays. We saw there was some flexibility in GP sessions to support this.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment and dealing with emergencies. We observed a whiteboard in the admin area where staff could write any issues/risks as they came across them. Staff told us they would also verbally inform the practice manager if they identified any issues or risks. These were then dealt with in a timely manner and were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage risk. We were told any identified risks were discussed at GP partners' meetings and within team meetings.

Areas of individual risk had been identified and steps taken to address any issues. For example, information relating to safeguarding was displayed throughout the practice. All staff had access to a panic button on the computer system to alert other members of staff should the need arise.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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 hear in an emergency). Staff told us they knew the location of this equipment and how to use it. We saw records that confirmed it was checked on a monthly basis.

Emergency medicines were available in a secure area of the practice. Staff checked the medicines on a monthly basis and we saw records that corroborated this. We checked the medicines at the time of inspection and found them all to be in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Identified risks included power failure, adverse weather and access to the building. The document contained relevant contact details for staff to refer. For example, water, gas and electricity suppliers. Both the GPs and practice manager held hard copies of the plan. Admin staff told us there was an 'emergency box' kept in the admin office which contained a copy of the plan, details of emergency contacts and also appointment record sheets, should the computer system go down.

The practice had carried out a fire risk assessment which included actions required to maintain fire safety. Records showed staff were up to date with fire training. The practice manager told us a fire drill and evacuation session was booked for May 2015.

The practice had purchased a collapsible zimmer frame which patients who had poor mobility could use in times of emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with best practice guidance. They accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told clinicians held weekly practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nursing staff they completed thorough assessments of patients' needs in line with NICE guidance and these were reviewed when appropriate.

We were informed GPs had a lead in specialist clinical areas such as palliative care and long term conditions. One of the GPs was the CCG lead for urgent care and the practice was involved in the avoiding unplanned admissions scheme. Patients who were at high risk of admission were informed of what they should do if they felt ill or felt their symptoms were worsening. They were also provided with fast access to a GP should the need arise.

There were systems in place to identify and monitor the health of vulnerable groups of patients. We were told patients who had learning disabilities were given longer appointments, annual reviews were undertaken and consent was documented in the patient's electronic record.

The practice had registers for patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). Patients were seen in a single appointment for their conditions rather than attending a disease specific clinic. This prevented patients having to attend multiple appointments and supported a holistic review of their condition.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a register of patients requiring palliative care. Regular meetings to discuss these patients' care needs were held with other appropriate professionals, such as members of the district nursing team and palliative care nurses.

Interviews with staff showed the culture of the practice was that patients were cared for and treated based on need. The practice took into account a patient's age, gender race and culture as appropriate and avoided any discriminatory practises.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduling clinical reviews, 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.

Information collected for the quality and outcomes framework (QOF) and performance against national screening programmes was used to monitor outcomes for patients. 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. In 2013/14 the practice was above both the local CCG and England average achievements for many of the QOF domains; particularly in depression and dementia.

Clinical audit, clinical supervision and staff meetings were used to assess performance. The practice had an effective system in place for how they completed clinical audit cycles. We were provided with summaries of three completed clinical audits which had been undertaken in the last twelve months. After each audit, actions had been identified and changes to treatment or care had been made. Where appropriate a repeat audit had been scheduled to ensure outcomes for patients had improved. We looked at two of these in detail. One audit showed repeat prescribing reviews were conducted and patients continued to receive prescribed medicines appropriately. Another audit looked at fast track referrals made by the practice, which identified they had all been appropriate and in line with NICE guidelines.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staff 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 and safeguarding adults and children.

GPs were up to date with their continuing professional development requirements and all have either been revalidated or had a date for revalidation. Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council (GMC) can the GP continue to practise and remain on the performers list with NHS England.

The practice nurse was expected to perform defined duties and was able to demonstrate they were trained to fulfil these duties. For example, cervical cytology and contraception advice. The practice nurse was registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The nurse we spoke with confirmed their professional development was up to date and they had received training necessary for their role.

All staff told us they felt supported in their role and confident they could raise any issues with the practice manager or the GPs. They had annual appraisals where any training needs were identified and confirmed the practice was proactive in supporting or providing relevant training.

Working with colleagues and other services

The practice worked with other service providers and held regular multidisciplinary meetings to monitor patients at risk, review patients' needs and manage complex cases. We saw minutes that identified other health professionals who attended these meetings, for example health visitors, district nursing staff and palliative care nurses.

The practice had systems in place to manage information from other services, such as hospitals and out of hours services (OOHs). Staff were aware of their responsibilities when processing discharge letters and test results.

One of the GPs was involved with both the CCG and LMC (Local Medical Committee). The practice manager attended a local practice managers' group where they could share information and expertise in practice management matters.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hours provider to enable patient data to be shared in a secure and timely manner.

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

Electronic systems were in place for making referrals which, in consultation with the patients, could be done through the Choose and Book system. The Choose and Book system 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 saw evidence where appropriate information was shared with other services and professionals to meet patients' needs. Shared access of specific information was available to the health visiting team, particularly around safeguarding children.

Information regarding consent for data sharing was available in reception, the practice leaflet and website.

Consent to care and treatment

We found the GPs were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004 and had recently attended training. Although there was no evidence to show whether other staff had attended training, the staff we spoke with understood the key parts of the legislation and how they implemented it in practice. Staff told us what they would do in a situation if someone was unable to give consent, this included escalating it for further advice where necessary.

Clinical staff we spoke with demonstrated a clear understanding of Gillick competency and Fraser guidelines. These are used to assess whether a child under 16 has the maturity and understanding to make their own decisions and give consent to treatments being proposed.

We were told how the GPs recorded consent on a patient's electronic record. The practice also recorded if a patient had given authority of lasting power of attorney to someone. A lasting power of attorney gives someone you trust the legal authority to make decisions on your behalf, if either you're unable to in the future or you no longer wish to make decisions for yourself.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice offered NHS Health Checks and all new patients aged 16 years or over were offered a patient health check with either the practice nurse or health care assistant.

All patients who were 75 years and over had a named GP and received an annual health check. Any of these patients who were identified as being socially isolated and felt lonely were signposted to the local Staying Well Ageing Better service, which specifically targeted loneliness in the elderly

Other patients who would benefit from social engagement and were aged 50 years and over were signposted to a local service known as SOFA (Southowram Over Fifties).

The practice offered a full range of immunisations for children, flu vaccinations and travel vaccinations in line with current national guidance. Data showed the practice had the highest uptake for influenza vaccination in Calderdale CCG. Patients aged 70, 78 and 79 years had also been invited for a shingles vaccination during the flu campaign. Data also showed the practice had achieved 100% immunisation cover for all eligible children under 12 months of age.

The practice was involved with national breast, bowel and cervical cytology screening programmes. They followed up any patient who had not attended their appointment. A recent audit had indicated a 2% increase in uptake of bowel screening following patients receiving a letter from the practice.

There was evidence of health promotion literature available in the reception area and practice leaflet. The practice website provided health promotion and prevention advice and had links to various other health websites, for example NHS Choices and NHS 111.

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 form the National Patient Survey (January 2015), where from a survey of 229 questionnaires, 114 (almost 50%) responses were received. The survey showed 97% of respondents rated their overall experience of the practice as good and 92% said the GP treated them with care and concern and were good at listening to them. These were all above average for the CCG (86% and 84% respectively).

Patients completed CQC comment cards to tell us what they thought about the practice. We received 42 completed cards which were all positive about the service they experienced. Many of the comments described staff as being extremely helpful, identified specific clinical staff as being 'amazing' and 'fantastic' and the service they received was 'first class'.

We also spoke with five patients on the day of our inspection who all told us they were satisfied with the care they received and staff treated them with dignity and respect. They told us the clinicians listened to them, explained treatments and involved them in decisions about their care. Data showed that 99% of respondents had confidence and trust in their GP.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting and treatment rooms to maintain patients' privacy and dignity 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.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour, or where a patient's privacy and dignity was not being respected they would raise these concerns with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

We observed reception staff were courteous, spoke respectfully to patients and were careful to follow the practice's confidentiality policy. We observed conversations between patients and staff in the reception area were not easily overheard. We were told there was a room available for patients who wished to speak privately to a member of reception staff.

Care planning and involvement in decisions about care and treatment

Both the patient survey information we reviewed and patients we spoke with on the day, rated the practice as good for involving them in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 85% of respondents said the GP involved them in care decisions and 92% felt they had enough time to make an informed decision about the choice of treatment they wished to receive. Both these results were above average compared to the local CCG.

Patients told us their long term health conditions were monitored and they felt supported. One patient under the age of 16 described how they were seen regularly by the same GP for their reviews, were spoken to appropriately and were involved in decisions about their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the CQC comment cards we received highlighted staff were caring, compassionate and provided support when needed.

Notices in the patient waiting area and on the practice website provided information on 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.

The practice maintained a carers' register and offered those patients an annual health check. The clinicians used these checks to assess how a carer was coping both emotionally and physically.

Both the practice manager and health care assistant had trained to be a Dementia Friend and could provide additional support to patients, carers and other practice staff as the need arose.

The practice had good follow up care for the families of bereaved patients. A sympathy card was sent and an appointment for bereavement support was offered.

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 Calderdale Clinical Commissioning Group (CCG) and other agencies to discuss the needs of patients and service improvements.

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. Longer GP appointments were available for patients who had complex needs. Patients with more than one long term condition had a single health check to avoid the need for multiple appointments. Home visits were also available for patients who found it difficult to access the surgery.

The practice provided a service for all age and population groups. Registers were maintained of patients who had a learning disability, a long term condition or required palliative care. These patients were discussed at the weekly clinical and monthly multidisciplinary meetings to ensure practitioners responded appropriately to the care needs of those patients.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. There was a hearing loop available for patients who had hearing impairment. There were systems in place which alerted staff to patients with specific needs or who may be at risk. For example, there was a pop up alert on a patient's electronic record to alert staff of any visual impairment.

There was good disabled access to the building and all patient areas and consulting rooms were on the ground floor. The patient areas were sufficiently spacious for wheelchair and pram access. Accessible toilet facilities were available for all patients and included baby changing facilities.

We were informed there was little diversity of ethnicity within their patient population. However, they told us how translation services could be accessed using language line (a telephone based system for patients who did not have English as a first language).

Access to the service

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey. This indicated patients were generally satisfied with the appointments system at the practice. For example, 92% of respondents described their experience of making an appointment as good (CCG 72%) and 87% of respondents found it easy to get through to the practice by telephone, which was higher than the CCG average of 70%. The majority of patients we spoke with said they found it easy to get an appointment but may have to wait longer to see a GP of their choice. At the time of our inspection the next available pre-bookable appointment was within 48 hours and there were some same day appointments available.

Information regarding the practice opening times and how to make an appointment was available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone, online or in person at the reception. Some appointments were pre-bookable up to two weeks for a GP and six weeks for a nurse. Home visits were offered for patients who found it difficult to access the surgery. There were also telephone appointments available at the end of every surgery, which clinicians used to give health advice to patients. The practice told us they undertake demand for appointments analysis on a regular basis and monitor the number of telephone consultations they undertake.

We were informed all children under five years of age were seen on the same day as requested. The practice also offered urgent care for patients who worked or studied away from home (out of area registrations). A text messaging service was used to remind patients (who had consented to receive them) 24 hours prior to their appointment.

Information was available in the practice and on their website regarding out of hours care provision when the practice was closed.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw information was available to help patients understand the complaints system both in the reception area, in the practice leaflet and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint, although all of them said they had not needed to make a complaint.

We looked at how complaints received by the practice in the last twelve months had been managed. The records showed complaints had been dealt with in line with the practice policy and in a timely way. Patients had received a response which detailed the outcomes of the investigations. We saw evidence that actions and learning from complaints was discussed at practice meetings and were shared with staff.

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 vision and practice values were documented in the practice statement of purpose. Our discussions with staff indicated the vision and values were embedded within the culture of the practice and patient care was a priority. These values were consistent with patients' experiences of the service.

Staff spoke positively about the practice, told us there was good teamwork and they felt valued as employees.

Governance arrangements

The practice had appropriate policies and procedures in place to govern activity and these were available to staff on the practice computer system. We looked at several policies and procedures and saw they had been reviewed annually and were up to date.

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 had achieved 97.5% of QOF points. We saw QOF data was regularly discussed at practice meetings.

The practice had an ongoing programme of clinical audits which were used to monitor quality and to identify where any action should be taken. The GPs clinical audits were often linked to medicines management or as a result of information from incidents. We saw audits of antibiotic prescribing trends and improvements to GP prescribing practice had been made as a result of these.

The practice had arrangements to identify, record and manage risk. Risk assessments had been carried out where risks were identified action plans had been produced and implemented.

We found there was an established management structure with clear allocation of responsibilities. The staff we spoke with all understood their roles and responsibilities and knew who to go to in the practice with any concerns. The management team and staff continually looked to improve the service they offered. Staff said they felt they delivered a high quality service and patients were happy with the care they received.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and all members of the management team were approachable, supportive and appreciative of their work. Systems were in place to encourage staff to raise concerns and a 'no blame' culture was evident at the practice.

The practice manager and GPs had a weekly meeting and staff meetings were monthly. We looked at the minutes from meetings and found that performance, quality and risks were discussed. Staff told us they were happy to raise any issues and felt their opinions were listened to and valued.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The results of the patient survey were available on the practice website. The practice also participated in the friend and family test.

The practice sought the views of patients through the Patient Participation Group (PPG) and the friend and family test. The practice had an active PPG of approximately 16 members, the majority of whom were in the 55 to 75 age range. The group met at least three times a year and was supported by the practice manager and GPs. Some of the members of the PPG attended Calderdale CCG health forum and provided feedback to the group. The PPG were encouraged to raise items for discussion and had made various suggestions which the practice had acted upon. For example, patients had identified it was difficult to get through to the practice when they opened in the morning. In response, staff working patterns had been adjusted (in consultation with staff) to provide more staff to answer the telephones at busy periods.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and staff and they felt valued as a member of the practice.

Management lead through learning and improvement

Are services well-led?

Good

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. They told us annual appraisals took place, which included a personal development plan. This was evidenced in the staff files we looked at.

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.