The Willows Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 24 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- There was an active Patient Participation Group who complimented the work of the surgery in the community.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also 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 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 named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and end of life care. It was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability, dementia and mental health issues. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place for patients where they had a lead GP responsible for all letters which came into the practice and were patient related. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The most recent information from Public Health England 2013/14 showed 91% of people would recommend this practice to others and 71% were happy with the opening hours.

We received 20 completed patient CQC comment cards and spoke with five patients on the day of our visit. Nineteen of these comments on the comment cards were positive about the care provided by the GPs, the nurses and reception staff with many comments conveying the excellent service they received by the practice overall. They all felt the doctors and nurses were competent and knowledgeable about their health needs. However, one comment card mentioned they had problems with an appointment at a specialised clinic and another did not always get an appointment which was suitable but did compliment the treatment they received from staff.

The Patient Participation Group (PPG) was active and ensured they contributed feedback about patients' views. They told us they had conducted their own patients' survey in 2014 and contributed to the practices' patient event where they had a stall to promote the PPG. There was also a suggestion box in the practice waiting room. All patients were happy with the cleanliness of the surgery.

The Willows Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP, a practice manager and a second CQC inspector.

Background to The Willows Medical Centre

The Willows Medical Centre surgery is located in Queensbury near Bradford. The building has good parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. The practice provides primary care services for 7350 patients under a Personal Medical Services (PMS) contract with NHS England in the Bradford Clinical Commissioning Group (CCG) area. The PMS contract is a contract between a general practices and NHS England for delivering primary care services to local communities.

The majority of the patients fall within the 22-64 years age range. Sixty six per cent of the patients have a long-standing health condition.

The practice has five GPs (three male and two females), an advanced nurse practioner, two nurses, one health care assistant and a community nursing team based at the practice comprising of a community matron, four nurses and a health care assistant working at the practice. They are supported by seven administration, health education promoter and reception staff.

The practice is open from 8.00am to 6.00pm Monday to Friday, with a late night surgery once a week on Monday evenings from 6.30pm to 8.00pm.

The practice treats patients of all ages and provides a range of medical services. When the practice is closed patients can access out of hours service via the NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note 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

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?

Detailed findings

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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew.

We carried out an announced visit on 24 February 2015. During our visit we spoke with a range of staff including the practice manager, service manager, two GPs, a nurse and two members of the reception staff. We also spoke with five patients on the day.

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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. For example, a recent medication had been issued in error by a local pharmacist. This was recorded by the practice as a significant event and the GP informed the pharmacist of the correct medication. This was therefore rectified immediately and an apology was issued by the pharmacist to the patient.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 15 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, which included receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms available on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked an incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of a reported incident, for example the medication error. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the patient service manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example, if there needed to be any appropriate adjustments made to medication.

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 staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example, there was a read coded child welfare template which flagged records and prompted contact with multidisciplinary team members such as the health visitors.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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). All staff had been trained to act as a chaperone. Reception staff would act as a chaperone if

nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

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

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw how the practice had dealt with a type 2 diabetes patient and the risks were explained on possible side effects and how they would deal with any future issues.

The nurses and the health care assistant administered vaccines using both patient specific and patient group directions which had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept secure at all times.

The practice had established a service for patients to pick up their dispensed prescriptions at local pharmacists and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure patients who collected medicines from these locations were given all the relevant information they required. For example, how often they should take them and any side effects.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out audits for each of the last three years and any improvements identified for action were completed on time. Minutes of practice meetings showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment (PPE) included disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. They told us how they would use a spillage kit and where it was located. Staff spoke positively about how they used PPE and how they had received training in hand washing techniques. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy 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 regular checks in line with this policy to reduce the risk of infection to staff and patients. The last legionella test was conducted in February 2015.

Good

Are services safe?

Equipment

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 and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers which indicated the last test date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy which set out the standards it followed when they recruited clinical and non-clinical staff. There was a checklist titled Safer Recruitment which showed pre and post appointment checks. For example, a date to identify when DBS checks were due and renewal of indemnity.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups which ensured enough staff were on duty. There was also an arrangement in place for members of staff, which included nursing and administrative staff, to cover each other's annual leave.

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. The practice manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

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. The practice manager told us these included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw any risks were discussed at GP partners' meetings and within team meetings. For example, the practice had shared with the team recent findings from a research paper which quoted the large number of bacteria which can be found on the bell of a stethoscope.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support, which included the use of the automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). Emergency equipment was available, this included access to oxygen and the AED. When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly. The notes of the practice's significant event meetings showed staff had discussed a medical emergency concerning a patient and the practice had learned from this.

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. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as cardiology, women's health and family planning. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed this happened. This was evident in how the practice managed respiratory tract infections in children.

The GP showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for older patients who lived with dementia. They monitored and reduced the prescribing of benzodiazepines and antipsychotics for those patients in line with national guidelines. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. This required patients to be reviewed by their GP according to need.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers. We saw minutes from meetings where regular reviews of elective and urgent referrals were made and improvements to practice were shared with all clinical staff.

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

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, scheduled clinical reviews, how they managed child protection alerts and medicines management. The information staff collected was then collated by the practice to support the practice to carry out clinical audits. An example of this was an audit on heart failure and renal failure due to soluble analgesia.

The practice showed us five clinical audits which had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes which resulted since the initial audit. For example, the practice audited the prolonged bisphosphonate use by patients. Bisphosphonates reduce the risk of osteoporotic fractures which can include hip and spine fractures. The aim of the audit was to ensure patients prescribed bisphosphonate were not at risk due to long term use. There was little evidence to guide GPs about the duration in how they prescribed this medication. The audit identified 26 patients who had used bisphosphonate for five years or more. The information was shared with GPs and the patients were called for a medication review. Twenty patients were identified as requiring an up to date scan. A second clinical audit was completed 11 months later which demonstrated no patient had been on the medication for more than 10 years. Two patients had been on the medication for five years but they were under a consultant and due a repeat scan.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for

Good

Are services effective?

(for example, treatment is effective)

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 practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and hypertension. This practice was routinely a high achiever in QOF was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in accordance with national guidance. In line with this, staff regularly checked patients who received repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long term conditions such as diabetes, and the latest prescribing guidance was being used.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a named GP for all palliative patients and advanced care plans were in place.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly 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 can the GP continue to practise and remain on the performers list with NHS England).

Staff we spoke with confirmed they had annual appraisals which identified learning needs from which action plans were documented. However, there were no regular 1:1 meetings with managers but staff said if they had an issue they would go direct to a manager and discuss the issue. Our interviews with staff confirmed the practice was proactive in providing training and relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, regarding administration of vaccines, cervical cytology, antenatal and postnatal care. Those with extended roles, for example the advanced nurse practitioner who saw patients with long-term conditions such as asthma and COPD, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results and letters from the local hospital, which included discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy which outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues which arose from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

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. Electronic systems were also in place for making referrals and the practice made 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). Staff reported this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and patients who needed advice on their weight.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways they identified patients who needed additional support and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 88%, which was better than the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. There was also a named nurse responsible who followed up patients who did not attend screening The practice audited this cohort of patients to see if there was any further non-attendance of appointments.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey undertaken in January 2015. From a survey of 297, 127 (43%) responses were received. The survey showed 93% of respondents rated their overall experience of the practice as good and 86% said the GP treated them with care, concern and were good at listening to them. 94% said the last nurse they saw or spoke to was good at treating them with care and concern.

A patient survey was undertaken by the practice's patient participation group (PPG) in April 2014 and 146 patient satisfaction questionnaires were completed by patients. The PPG prepared an analysis of the results and the practice had implemented these from an action plan. This included to improve communication with patients, improve patient involvement, improve access to appointments and to develop the role of the PPG.

The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed patient satisfaction scores on consultations with doctors and nurses, with 95% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 20 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. There was a system in place which allowed only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 83% of respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

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

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us if families had suffered bereavement, they would be contacted by someone from the practice. A patient comment card gave high praise about the staff when the patient suffered a bereavement of someone close. They confirmed they had received support from the practice and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

For example, longer GP and nurse appointments were available for patients who had complex needs or where they were supported by a carer. 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 ages 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 regular clinical and multidisciplinary meetings to ensure practitioners responded to the care needs of those patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example to assist in the review of the website for patients to make it more user friendly and to improve access to appointments. The PPG held an event in the community where it was marketed as Free Spring MOT; the clinicians also attended and offered cholesterol tests, blood pressure monitoring and diabetes tests.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. The practice had systems in place which alerted staff to patients with specific needs or who may be at risk. For example, patients who had a visual or hearing impairment were flagged on the computer system.

There was good disabled access to the building and all patient areas and consulting rooms were on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

The practice had a high population of English speaking patients though it could cater for other different languages through translation services, which was a telephone based system for patients who did not have English as a first language.

The practice had patients who were hard of hearing and a person who uses sign language accompanied them. Staff were aware of people with hearing difficulties and so did not use the tannoy system but escorted them to the consultation room.

Access to the service

Appointments were available from 8am to 6pm on weekdays, with extended hours on a Monday evening by appointment only from 6:30pm to 8pm.

Comprehensive information was available to patients about appointments on the practice website and the practice leaflet This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients required out of hours medical attention they were asked to contact NHS 111 for the out-of-hours service.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who could not access the practice, for example housebound patients. Home visits were made to two local care homes by the on call GP.

Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice.

The practice's extended opening hours on a Monday evening was particularly useful to patients with work commitments. Patients also spoke very positively about

Good

Are services responsive to people's needs?

(for example, to feedback?)

getting appointments on the day and use of the rapid access and telephone consultations in a morning from 8am to 9:15am where patients received advice on a telephone consultation. If necessary the patients would then be seen at the rapid access clinic which ran from 9:30am.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. This was in the practice leaflet and on their website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency in dealing with the compliant. If the complainant was not happy with how the complaint had been resolved there were details of who else they could contact.

The practice reviewed complaints annually to detect themes or trends and no themes had been identified. Lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were part of the practice's strategy. These values were clearly displayed in the practice leaflet and on the practice website. The practice vision and values included right patient, right time, right treatment and to provide the best possible care for the patients with the resources available.

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

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a selection of these policies and procedures and staff we spoke with confirmed they had read the policy. All the policies and procedures we looked at had been reviewed annually and were up to date. Although we did notice the cold chain policy in use from Bradford & Airedale CCG was due for renewal

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GPs were the lead for safeguarding adults and vulnerable children. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice had arrangements which identified, recorded and managed risks. The practice had an ongoing programme of clinical audits which were used to monitor quality, ensure the practice was achieving targets and delivered safe, effective, caring, responsive and well led care. For example salt and hypertension which showed by decreasing the intake of salt there was a significant reduction in blood pressure.

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

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies. For example the recruitment policy, supervision and appraisal policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and 86% of patients agreed the rapid access telephone consultations were useful. We saw as a result of this the practice had introduced an action plan to improve further the access to appointments. We reviewed a recent practice report on comments from patients, which had a common theme of improving communication to patients. For example, via the patient registration pack, the newsletter and website, to ensure patients were informed about the practice.

The practice had an active patient participation group (PPG) which has remained constant in size. The PPG included representatives from various population groups. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they

Are services well-led?

Good

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

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and but could not see any evidence of appraisals. However, staff we spoke with confirmed annual appraisals did take place told us that the practice was very supportive of training and they had protected learning time.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw examples of this from minutes of the meetings. The GPs we spoke with told us how plans had since been developed to ensure they were looked at more regularly.