Primrose Surgery

Quality Report

Hillside Bridge Health Care Centre
4 Butler Street West
Bradford
BD3 0BS
Tel: 01274 729602
Website: www.ThePrimroseSurgery.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced inspection visit on 5th November 2014. The overall rating for the practice was good.

Our key findings were as follows:

- Where incidents had been identified relating to safety, staff had been made aware of the outcome and action taken where appropriate, to keep people safe.
- All areas of the practice were visibly clean and where issues had been identified relating to infection control, action had been taken.
- Patients received care according to professional best practice clinical guidelines. The practice had regular information updates, which informed staff about new guidance to ensure they were up to date with best practice.
- The service ensured patients received accessible, individual care, whilst respecting their needs and wishes.
- We found there were positive working relationships between staff and other healthcare professionals involved in the delivery of service.

We saw several areas of outstanding practice including:

- The practice actively supported patients who may be vulnerable, including homeless and travelling people.
- The practice used translated notices and colour coded signage to assist patients whose first language was not English.

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

- The practice did not complete all the checks to ensure staff were safe to work at the practice. We found staff recruitment procedures were not effective and should be reviewed.

Professor Steve Field CBE FRCP FFPH FRCGP

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

Overall the practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to improve the quality of the service. Information about safety was recorded, monitored, appropriately reviewed and addressed.

The practice was clean and infection control well managed. There were safe systems in place to monitor medicines and a consistent auditing of medical equipment for safety.

We confirmed there were adequate staffing levels and a good mix of skills in the team. However we found staff recruitment could be managed in a safer manner, staff recruitment procedures were not effective.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were consistently met and referrals to secondary care were made in a timely manner. Healthcare professionals ensured patients' consent to treatment was obtained.

Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out supervision and appraisals for staff.

There were regular practice meetings and evidence of positive working relationships with multidisciplinary teams. National Institute of Health and Care Excellence (NICE) guidance was referenced and used routinely. It was evident in practice and clinical meetings NICE guidelines were discussed and plans made for their implementation.

The practice raised awareness of health promotion in consultation, treatment rooms, the practice waiting areas and their web site. There were screening programmes in place to ensure patients were supported with their health needs in a timely way.

Are services caring?

Good

The practice is rated as good for providing caring services. All the patients who responded to CQC comment cards, and those we spoke with during our inspection, were very positive about the service. They all confirmed staff were caring and compassionate and respected their privacy and dignity.

Summary of findings

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. The GP and staff understood the diverse needs of the different population groups they supported and made arrangements for these to be met. Systems were in place to obtain feedback from patient's opinion of the service they received. The results of this informed planning to develop the service further and improve the care and treatment for patients.

Are services well-led?

Good 

The practice is rated as good for being well-led. There was a long standing visible management team, with a clear leadership structure. Staff felt supported by the management team. There were objectives and action planning for the future. There were good governance arrangements and systems in place to monitor quality and identify risk.

The practice had an active patient group called the Patient Representative Group (PRG). This group was positively involved and instrumental in monitoring the quality and development of the practice.

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 patients. The practice supported older patients by ensuring all patients over 75 years had a named GP. This included those who had good health and those who may have one or more long-term conditions. There were systems in place for older patients to have regular health checks and timely referrals were made to secondary care. The practice supported patients with dementia and end of life care. They were responsive to the needs of older patients, including offering home visits and urgent appointments for those vulnerable patients with additional needs. Good information was available to carers. Older patients were also represented on the Patient Representative Group (PPG).

People with long term conditions

Good

The practice is rated as good for the care of patients with long term conditions. There was proactive intervention and regular health reviews for patients depending on their needs. Patients had a lead GP and nurse for their condition and structured reviews to check their medication needs. The practice held a register of patients with long term conditions, which enabled the practice to monitor this population group needs as a whole.

Patients with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so staff could respond to their changing needs. Information was made available to out of hours providers for those on end of life care to ensure appropriate care and support was offered.

The practice had regular clinics for conditions such as diabetes and asthma to ensure patients' conditions were appropriately monitored, and involved in making decisions about their care. The practice had good systems in place to contact non-attenders to ensure their health was continually supported.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. 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.

Summary of findings

There were designated mother and baby clinics, and people could also access midwife services at the practice. Full post natal and six week baby checks were carried out by GPs and regular baby clinics could be accessed.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients, including those recently retired and students. The practice was proactive in offering a clinical telephone triage system which supported working patients to access the practice whilst causing minimal disruption to their working day. They offered electronic appointment, prescription services and telephone consultations where appropriate.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice actively supported patients who may be vulnerable, including homeless people, travelling people and those with a learning disability. The practice also had good links with a local homeless support agency and supported transient patients with their health needs.

Annual health checks for people with a learning disability were completed. There was systems in place to monitor and support vulnerable patients who required extra support, for instance if they were a carer. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies.

The practice also had arrangements in place for longer appointments to be made available where patients required translation services. There was a hearing loop system for patients who had hearing difficulties and information available in additional languages and colour coded signage for individuals with language difficulties or visual impairment.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia).The practice had access to professional support such as the local mental health team and psychiatric support as appropriate. The practice monitored patients with poor mental health according to clinical quality indicators and in line with good practice guidelines.

Summary of findings

The practice had supported patients experiencing poor mental health in accessing various support groups such as MIND. It also had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Repeat prescribing for patients receiving medication for mental health needs was monitored by the GP.

Summary of findings

What people who use the service say

In the most recent information from Public Health England showed that 83% of people would recommend this practice to others and 80% were happy with the opening hours. The practice produced their own 2014 patient annual survey, of 157 responses, 93% of patients rated their experience at the practice as good or excellent.

Comments on the NHS choices website showed the majority of patients surveyed were satisfied with the arrangements the practice had made for meeting their needs and said they would recommend the practice to someone moving into the area. Almost all of the patients surveyed said they would be happy to see the same GP again.

We received 20 completed patient CQC comment cards and spoke with five patients on the day of our visit. We spoke with people from different age groups and people who had different physical care needs and who had varying levels of contact with the practice. All these patients were complimentary about the care provided by the GP and the nurses and reception staff. They all felt the doctors and nurses were competent and knowledgeable about their personal treatment needs. The two negative comments received via the comment cards and also reflected in the patient questionnaire were about access to booked appointments. The practice had responded to these concerns and along with the PRG had looked at ways to improve the service. They had introduced an on line booking system via their web site and set up text messaging to remind patients of their appointments.

We spoke to two members of the Patient Representative Group (PRG) who felt they were well supported by the management team and their ideas and suggestions were listened to and acted upon.

Areas for improvement

Action the service SHOULD take to improve

- Whilst the practice had a recruitment policy in place, it did not cover all of the essential checks required and needed updating to ensure it complied with national guidance and legislation.

Outstanding practice

- The practice actively supported patients who may be vulnerable, including homeless people, travelling people and those with a learning disability.
- The practice used translated notices and colour coded signage to assist patients where their first language was not English.

Primrose Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Primrose Surgery

Primrose Surgery is located within the Hillside Bridge Health Care Centre sharing the facilities with other health care providers. The building is a modern purpose built health centre with good parking facilities and disabled access.

The practice is registered with the CQC to provide primary care services. It provides Personal Medical Services (PMS) for 4,841 patients under a PMS contract with NHS England in the Bradford City Clinical Commissioning Group (CCG) area.

The practice has two GP partners, a practice manager, an advanced practioner, practice nurse, two healthcare assistants and an experienced administration and reception team. The reception team consists of one deputy practice manager and seven reception and administrative staff.

The practice is open Monday to Friday from 8.00am to 6.30pm with extended opening hours on a Saturday morning 8.30am to 11.30am over the winter period. The practice treats patients of all ages and provides a range of medical services. Patients also have access to primary care services such as health visitors and midwives, district nurses and a pharmacy.

When the practice is closed patients can access the out of hour's provider service via NHS 111 service.

The practice is situated in an area of high deprivation. The practice population is made up of a predominately younger population between the ages of 0- 35 years old and a lower than national average of patients aged over 65 years. Twenty One per cent have a caring responsibility. Forty Three per cent of the population have a long-standing health condition.

Why we carried out this inspection

This inspection was part of comprehensive programme of inspections of general practices. This practice was part of a random selection of practices in the Bradford City CCG area. This provider had not been inspected before and that was why we included them.

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.

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?

Detailed findings

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

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

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

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

We carried out an announced visit on 5th November 2014. During our visit we spoke with a range of staff including the practice manager, two GP partners, one advanced nurse practioner, one health care assistant and four reception staff. We also spoke with five patients and two members of the practice's patient representative group.

We observed communication and interactions between staff and patients both face to face and on the telephone within the reception area. We reviewed 20 CQC comment cards where patients and members of the public 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 had systems in place to monitor all aspects of patient safety. Information from the Clinical Commissioning Group (CCG) and NHS England indicated the practice had a good track record for maintaining patient safety. Staff we spoke with understood their responsibilities to raise significant events. This included the process to report them internally and externally where appropriate.

Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the practice was appropriately identifying and reporting incidents.

There were policies and protocols for safeguarding vulnerable adults and children. Any concerns regarding the safeguarding of patients were passed onto the relevant authority. Learning and improvement from safety incidents

When incidents occurred the practice had systems in place to ensure there was effective learning in order to minimise the likelihood of such events recurring. There were effective protocols in use to scrutinise practice. We saw records of significant events that had occurred during the last 12 months. We saw they were discussed at monthly practice meetings which all clinical and non-clinical staff attended. For instance there had been an error in the administration of vaccine to a patient, this was discussed at the practice meeting and action put in place to minimise future risk.

Staff told us they felt confident in raising issues to be considered at the meetings and felt action would be taken. A culture of openness operated throughout the practice, which encouraged errors and 'near misses' to be reported.

Reliable safety systems and processes including safeguarding

The practice had systems in place to protect and safeguard children and vulnerable adults. The practice had a named lead GP in safeguarding vulnerable adults and children. They had completed level three training to enable them to fulfil this role. All other staff received appropriate training for safeguarding adults and children and were aware of relevant procedures. We asked members of clinical and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. We saw evidence that recent concerns regarding the safeguarding of a child were promptly passed on to the relevant authorities by staff.

The computer software used by the practice meant staff entered codes which then flagged up where a patient (child or adult) was vulnerable or required additional support, for instance if they were a carer. The practice also had systems to monitor babies and children who failed to attend for health checks, childhood immunisations, or who had high levels of attendances at A&E.

There was evidence of patients being offered chaperone services during consultation and treatment and staff had appropriate guidance and training.

Medicines management

The practice was not a dispensing practice. The amount of medicines stored was closely monitored and medicines were kept in a secure store with access by clinical staff only. 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 for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Staff confirmed the procedure to check the refrigerator temperature every day and ensure the vaccines were in date and stored at the correct temperature. The staff showed us their daily records of the temperature recordings and that the correct temperature for storage was maintained. The cold chain for vaccines was audited and closely monitored by staff.

There were systems in place to ensure GPs regularly monitored patients medication and re issuing of medication was closely monitored, with patients invited to book a 'medication review', where required. The practice employed a part time pharmacist to monitor medicines and ensure the prescribing of medicines was safe. This was to confirm the practice operated in line with national NHS guidelines. They were also responsible for reviewing prescriptions and patient's medication.

We saw practice meetings recorded the actions taken in response to the review of prescribing data and medicines audits. For example, an audit of vaccinations identified a potential training need for staff and review of procedure.

Good

Are services safe?

There were standard operating procedures (SOP) in place for the use of certain medicines and equipment. The nurses used patient group directives (PGD). PGDs are specific written instructions which allow some registered health professionals to supply and/or administer a specified medicine to a predefined group of patients, without them having to see a doctor for treatment. For example, flu vaccines and holiday immunisations. PGDs ensure all clinical staff follow the same procedures and do so safely. The data from 2013 NHS England showed 95% of children aged 24 months at the practice had received their vaccinations.

There was a process to regularly review patients' repeat prescriptions to ensure they were still appropriate and necessary. Any changes in medication guidance were communicated to clinical staff, and staff were able to describe an example of a recent medical alert and what action had been taken. 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 securely at all times.

Cleanliness and infection control

We saw all areas in the practice were clean. 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.

We noted liquid soap and paper hand towels were available in treatment and public areas. Staff told us they accessed Personal Protective Equipment (PPE). Single use equipment was safely managed and was part of the infection control audit. Suitable arrangements had been made which ensured the practice was cleaned to a satisfactory standard.

We saw appropriate sharps receptacles in place in the treatment rooms. Separate containers were provided for the disposal of cytotoxic and contaminated sharps such as used needles. Staff told us they ensured spillage kits were available to clean areas contaminated with body fluids. The practice had a needle stick injury policy in place, which outlined what staff should do and who to contact if they suffered this injury. There was an up-to-date Infection Control Policy in place. An external NHS infection control audit had been undertaken within the last week and the practice received an overall rating of safety of 98%.

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. We saw infection control training had been completed by all the staff and refresher training was done on an annual basis. An infection control checklist was used to help identify any shortfalls or areas of poor practice. Where concerns were identified, an action plan was put in place. Discussions regarding infection control took place in staff meetings.

The practice had legionella assessments and audits in place. The practice had suitable and sufficient risk assessments required to identify and assess the risk of exposure to legionella bacteria from work activities. Water systems on the premises were checked to ensure continued safety.

Equipment

The practice had appropriate equipment for managing emergencies. Emergency equipment included a defibrillator and oxygen. These were readily available for use in a medical emergency and was checked each day to ensure they were in working condition. Resuscitation equipment and medication was easily accessible.

Staff told us they were clear about the action to take in the event of a medical emergency. All relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training.

A log of maintenance of clinical and emergency equipment was in place and staff recorded when any items identified as faulty were repaired or replaced.

We saw the practice had annual contracts in place for portable appliance tests (PAT) and also for the routine servicing and calibration, where needed, of medical equipment.

Staffing and recruitment

The practice had a recruitment policy in place dated April 2014. The policy stated all staff should have two references from their previous employment. We looked at the staff files for the most recent staff employed; one clinical and two non-clinical staff. We saw staff had been employed

without references in place before they commenced working at the practice. The practice manager explained it was normal for employment to commence subject to satisfactory references. References were obtained after staff were employed. We found therefore staff recruitment procedures were not robust and should be reviewed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There were arrangements in place for members of staff, including GP's, nursing and administrative staff to cover sickness and annual leave. The staff reported there was generally a sufficient pool of staff to cover all eventualities, and they rarely had to use locums.

Monitoring safety and responding to risk

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had a health and safety policy setting out the steps to take to protect staff and patients from the risk of harm or accidents. There were systems in place to monitor safety in the practice and report problems that occurred. There was a designated health and safety lead who carried out a monthly risk assessment covering such areas as the safety of the building and equipment. Arrangements were in place to protect patients and staff from harm in the event of a fire. This included staff designated as leads in fire safety and carrying out appropriate fire equipment checks. There was evidence learning from incidents and responding to risk had taken place and appropriate changes implemented. The practice management team looked at safety incidents and any concerns raised. They then looked at how this could have been managed better or avoided. They also reported to external bodies such as the Clinical Commissioning Groups (CCG), the local authority and NHS England in a timely manner. The practice was positively managing risk for patients. Patients with a significant change in their condition or new diagnosis were discussed each week at clinical meetings, which allowed clinicians to monitor treatment and adjust support according to risk. A dedicated telephone line had also been made available for patients, for instance those receiving palliative care, to access the surgery easily and obtain support. Information regarding palliative care patients was made available to out of hours providers so they would be aware of changing risks.

Arrangements to deal with emergencies and major incidents

Emergency medicines were available, such as for the treatment of cardiac arrest and anaphylaxis, and all staff knew their location. Processes were in place to check emergency medicines were within their expiry date.

There were disaster/ business continuity plans in place to deal with emergencies that may interrupt the smooth running of the service such as power cuts and adverse weather conditions. The plans were accessible to all staff and kept in reception. The plan included an assessment of potential risks that could affect the day-to-day running of the practice. This provided information about contingency arrangements staff will follow in the event of a foreseeable emergency. The practice manager told us they had put their emergency plan into action during a recent incident where they had a major computer failure. The practice reviewed the plan following the incident to assess the impact and robustness of the plan to minimise future impact on the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice achieved 92.37 per cent of the QOF framework points in year 2012/13, which showed their commitment to providing good quality of care. We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as asthma and diabetes.

We saw minutes of practice meetings where new guidelines were shared with staff, 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 that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice aimed to meet the health needs of all groups of patients for instance new patients, mother and babies, older people and vulnerable groups such as the homeless.

We found that the practice completed full health checks on new patients and follow on support for any identified health needs. Special clinics for health needs such as, coronary heart disease, diabetes, asthma and COPD were held and systems were in place to identify patients who met the criteria to attend. Mothers and babies were supported with antenatal clinics, with health visitor support and child health and immunisation clinics.

The practice liaised with homeless agencies such as the Salvation Army to provide emergency appointments for homeless people and also provided health support for transient groups such as travelling people.

There was a register of patients with learning disabilities and evidence of regular annual health checks. To accommodate the needs of this group longer appointments and home visits were made available. There were systems in place to identify and monitor the health of vulnerable groups of patients. Specific coding was used for instance to identify carers to ensure regular health checks and support was put into place.

The practice ensured follow up consultations were in place following older patients when discharged from hospital. Patients over the age of 75 had a named GP. Annual health checks were in place for the over 75s and their medication was reviewed. Patients told us they were included in their care decisions and health promotion programmes were available.

Staff were able to demonstrate how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice kept up to date disease registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual, or as required, health reviews.

Feedback from patients confirmed they were referred to other services or hospital when required. 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 referral, for instance two week referrals for patients with suspected cancer were done there and then, and other routine referrals were done within seven days.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing clinical audit cycles. Examples of clinical audits included antibiotic prescribing, review of hepatitis B and C and a review of indicators in patients at high risk of developing diabetes.

The practice was making use of clinical audit tools in both clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved.

We saw the practice monitored patients with poor mental health; they had audits which ensured patients had a regular health check and systems in place to follow up if there was non-attendance.

Staff regularly checked that all routine health checks were completed for long-term conditions such as diabetes and

that the latest prescribing guidance was being used. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed the GPs had oversight and a good understanding of best treatment for each patient's needs.

The local CCG organised themselves into neighbourhood teams. The GP's from the practice met regularly with the CCG and other practices. These meetings shared information, good practice and national developments and guidelines for implementation and consideration.

Effective staffing

We saw checks were made on qualifications and professional registration as part of the recruitment process and additional checks throughout the clinician's appointment. There was a comprehensive induction programme in place for new staff which covered generic issues such as fire safety and infection control. We saw evidence staff had completed mandatory training, for example basic life support and safeguarding and infection control.

The practice manager told us the staff completed some training electronically and other training at their monthly training sessions. Staff had trained in areas specific to their role for example, epilepsy care, wound management, heart disease, diabetes and COPD.

We saw evidence of regular in house training for all staff to attend. For instance recently they had training in cardiopulmonary resuscitation (CPR) and Fire safety.

All GPs were up to date with their continuing professional development requirements and all either have been revalidated or had a date for revalidation. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain registration they had to complete regular training and update their skills. The advanced nurse practioner we spoke with confirmed their professional development training was up to date.

The clinical and non-clinical staff confirmed they received on going appraisal. They told us it was an opportunity to discuss their performance, any training concerns or issues they had. All the staff we spoke with said they were supported in their role and confident in raising any issues with the practice manager or the GPs.

There were Human Resources (HR) policies and procedures in place to support poor or variable performance amongst staff, and we saw where poor performance had been identified appropriate action had been taken to manage this

Working with colleagues and other services

We saw evidence the practice worked closely with other professionals. For example they worked with palliative care nurses, health visitors, social services and care home staff to support elderly people and people with learning disabilities. Specialised training and care plans had been developed to assist staff in meeting the needs of these patients.

The staff attended multidisciplinary team meetings every three months 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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient's care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. We saw audits in place to assess the completeness of these records and action had been taken to address any shortcomings identified.

We spoke with practice staff about the formal arrangements for working with other health services, such as consultants and hospitals. They told us how they referred patients for secondary (hospital) care and booked an appointment using the 'choose and book' system before the patient left the surgery.

Good

Are services effective?

(for example, treatment is effective)

The staff told us they liaised closely with the health and social care providers to ensure any health needs of their patients were promptly addressed, for example when someone was discharged from hospital. This was important to ensure integrated care and support was provided to the patients. They also worked with the out of hours service to make sure doctors had full information about patients' needs including care plans for older patients and those who received palliative care.

Consent to care and treatment

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 to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us they spent time discussing treatment options and plans with patients and were aware of consent procedures. They explained discussions were held with patients to assure their consent prior to treatment.

There was a practice policy on consent in place. Staff were able to provide examples of how they dealt with a situation if someone hadn't been able to give consent, including escalating this for further advice to a senior member of staff where necessary.

We saw clinical staff were familiar with the need for capacity assessments and Gillick competency assessments of children and young people. These assessments check whether children and young people had the maturity to make decisions about their treatment.

We found clinical staff understood how to facilitate 'best interest' decisions for people who lacked capacity and seek appropriate approval for treatments such as vaccinations from children's legal guardian.

Health promotion and prevention

The practice raised patients' awareness of health promotion. This was via their web site and leaflets in the practice. This information covered a variety of health topics including smoking cessation, stroke and diabetes.

The practice held flu virus and shingles vaccination sessions and provided child immunisation programmes. We saw the practice website included information about how to access appropriate influenza advice and support. Patients confirmed with us they had access to the information and staff regularly discussed health promotion with them during their consultations and on home visits.

The practice held regular clinics to support areas such as asthma; chronic obstructive pulmonary disease (COPD), diabetes and support sessions for weight management, exercise and smoking cessation.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Reception staff were courteous and spoke respectfully to patients. They listened to patients and responded appropriately. Of the patients who participated in the national GP patient survey in 2013, 93% said they found receptionists at the practice 'helpful'. A similar high level of satisfaction was found when respondents to the in-practice patient survey were asked about the reception team.

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 so that patient's privacy and dignity was maintained during examinations, investigations and treatments. We noted doors were closed during consultations and conversations taking place in these rooms could not be overheard.

The staff were aware of the practice policy on chaperoning and familiar with arrangements to maintain the dignity and privacy of patients undergoing intimate examinations. Patients' on going emotional needs were supported. We saw leaflets were available in the waiting room which offered support to patients for areas such as; bereavement counselling, mental health support and also support with conditions such as cancer.

Care planning and involvement in decisions about care and treatment

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the national GP patient survey in 2013, 75% of respondents said the GP they visited was 'good' at involving them in decisions about their care. They also expressed their GP had satisfactorily explained their condition and the treatment they needed. Of the five patients we spoke with, all said they had been involved in decisions about their care and treatment, and staff explained things clearly to them.

We found staff communicated with patients so they understood their care, treatment or condition. We received positive comments from patients confirming they understood their treatment and options were discussed during their consultation.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients of this service.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. Notices in the patient waiting room and patient website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was written information available for carers to ensure they understood the support available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service for all age groups. They covered patients with diverse cultural and ethnic needs and those living in deprived areas. We found GPs and other staff had the overall competence to assess each patient and were familiar with the individual needs and the impact of their socio-economic environment.

Longer appointments were made available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. There was a register of the housebound and home visits were made to local care homes and to those individual patients who needed one.

The practice has in place a dedicated member of staff who was the 'Patient Involvement Lead'. Their role was to ensure patients have the right information about what the practice can provide and local voluntary organisations which may be of benefit to the patient.

Hearing loops were installed for patients with hearing problems. There was a large waiting room which was easily accessible to wheelchairs.

We confirmed there was a process in place for 'Choose and Book' referrals to other services. We saw referrals the practice made to other services and saw these were done in a timely manner and contained relevant information. Patients who required an urgent referral were responded to effectively and the provider had processes in place to check they had been received, for example by the hospital.

We looked at how the practice met the needs of older people. We saw the practice had a named GP for over 75s and provided patients with an 'elderly health check' to support them with management of any long term conditions. This included a system that recalled patients annually for a comprehensive review.

The practice was part of a CCG initiated campaign to health screen in the area for potential diabetes. New patients had been identified and supported with their health needs.

Staff understood the lifestyle risk factors that affect some groups of patients within the practice population.
We confirmed that the practice provided a range of services and clinics where the aim was to help particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation programmes, and advice on weight and diet.

The practice had a patient representative group formed in 2003, which now consisted of eleven members. We were able to speak to two members of the group who said they felt the practice valued their contribution. The practice shared relevant information with the group and ensured their views were listened to and used to improve the service offered at the practice. For instance they had discussed the difficulties of patients not accessing appointments and continued non-attendance for appointments and how the practice can meet different language needs. The group discussed strategies of how they can better manage these areas within the practice.

Tackling inequity and promoting equality

We found the practice was accessible to patients with mobility difficulties, there was a disabled ramp at the front entrance, disabled parking bays and the premises were all on one level. We saw 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.

There was a practice leaflet and health promotion information available. There was signage in other languages and coloured coded doors to enable patients with language difficulties and the visually impaired. There was also a hearing loop available. There was an interpreter service for patients with language difficulties and longer appointments made if required.

The practice provided support to homeless and travelling people in the area and emergency appointments were made when required. The practice provided health promotional literature for these and other groups and advertised the service of support groups including Citizens Advice who hold three sessions per week at the practice. They help patients with any benefit, money, employment, housing, immigration and other issues.

Access to the service

We saw that the practice ensured patients could access appointments and order repeat prescriptions. The

Are services responsive to people's needs?

(for example, to feedback?)

practice was open from 8.00am to 6.30pm on weekdays. Patients could use the web site, telephone or visit the surgery to make appointments or order prescriptions. Opening times and closures were on the practice website and in the practice leaflet with an explanation of what services were available. We confirmed that an extended winter service was offered on Saturday mornings.

To ensure urgent cases were seen the practice operated a telephone triage system for appointments which patients were seen promptly. All children were seen the same day and usually within two hours of contacting the practice. We found that home visits were also available where required for instance housebound patients and those living in care and nursing homes.

Patients we spoke with said they had timely diagnosis and referrals and access to specialist support from other health providers including NHS hospitals.

Listening and learning from concerns and complaints

The practice completed their own annual survey via the PRG group and published the results. A plan was drawn to identify action to be taken. Results of the survey were displayed in reception.

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

The practice also has a member of staff who is designated as the 'complaints liaison officer', whose role is to invite patients to initially discuss their concerns and to monitor suggestions, concerns and complaints made.

We saw information was available to help patients understand the complaints system. Information on how to make a complaint was available in a practice booklet in reception. There is a suggestion box available in the waiting area for patients use. 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.

The practice manager kept a log of complaints about the practice. Whist there were only a few complaints over the past 12 months it was clear these were investigated and concluded in accordance with their own guidelines and procedures. We saw these investigations were thorough and impartial and learning from these was discussed at practice meetings.

Are services well-led?

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

Our findings

Vision and strategy

We found details of the vision and practice values within the 'Patients charter' held in the practice leaflet. The charter stated the practice, 'aims to provide you with the best possible treatment and advice at all times to help you keep healthy. We are committed to ensuring high standards of care for you and your family and we seek your support in working together'.

The staff had worked hard and the quality of the service had improved over the last year. The GPs were positive about the improvements and had recognised that further team building and development was very important to ensure everyone was working towards shared visions and values and better outcomes for patients.

We saw there was input from key stakeholders, patients and staff which ensured the practice regularly reviewed their aims to ensure they were being met.

Governance arrangements

There was a management structure with clear allocations of responsibilities, such as lead roles. Staff said they were all clear about their own roles and responsibilities. We spoke with nine members of staff including GPs, advanced nurse practioner, health care assistants, reception and administration staff. They were all clear about their roles and responsibilities. We found effective monitoring took place, and this included audits to ensure the practice was achieving targets and delivering safe, effective, caring, responsive and well led care. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as management and safety of medicines. We saw the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example in relation to the management of medicines and vaccines.

The practice sought feedback from patients and staff to help improve the service. All the staff we spoke with felt they had a voice and the practice was supportive and created a positive learning environment.

Care and treatment was provided by a multidisciplinary team in which full use was made of all the team members. For example, clinical meetings were held monthly and practice meetings every three months.

Leadership, openness and transparency

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, disciplinary procedures, induction policy and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had an active patient representative group (PRG). The PRG mostly reflected the population diversity of the practice population and was actively advertising to recruit younger members (16-18) to the group to ensure it was representative of the practice population as a whole. We spoke to two members of the group who were very positive about their role and contribution to the quality of the service. They were able to give us several examples of where the group had been involved with improvements at the practice. For instance, the PRG was active in health promotion informing patients of the 'Shingles' vaccine being available and other health initiatives. They were also instrumental in creating more capacity for pre-bookable appointments, management of cancelled appointments and interpretation of signage for patients.

The practice had gathered feedback from staff, through staff training days and generally through staff meetings, appraisals and discussions. Staff confirmed they felt 'listened to' by management and opinions were respected and involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Are services well-led?

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

Staff confirmed they were supported to maintain their clinical professional development through training and mentoring. Staff also attended regular practice meetings and action and learning were shared throughout the team. We saw evidence the practice improved the service following learning from incidents and reflecting on their work.