Queens Road Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Queens road surgery on 21 April 2015. Overall the practice is rated as good.

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 older people, people with long term conditions, families, children and young people and the working age population.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed, including those relating to recruitment checks.
- 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. Complaints would be addressed in a timely manner and the practice endeavoured to resolve complaints to a satisfactory conclusion.
- Patients said they found it easy to make an appointment with a named GP and that 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.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles. The practice carried out regular appraisals and put in place personal development plans for staff.

Are services caring?

Good

The practice is rated as good for caring. Patient surveys showed that the practice compared favourably with other practices in the area. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Readily available information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, a named GP and continuity of care, with urgent appointments available on the same day.

Are services well-led?

Good

The practice is rated as good for well-led. The leadership team were effective and had a clear vision and purpose. There were systems in

Summary of findings

place to drive continuous improvement. Governance structures were in place and there was a robust system that ensured risks to patients were minimised. There was an active patient participation group to monitor the quality of the service delivered by 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 people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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 care. The practice was responsive to the needs of older people and where appropriate provided home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. Patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with 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 population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and those who were at risk. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 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 which reflected the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a record of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice offered longer appointments for people with learning disabilities. All GPs had attended level three safeguarding training.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health including people with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of our visit and received 40 completed CQC comment cards. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

The patients were complimentary about the care provided by the staff, their overall friendliness and behaviour of all staff. They felt the doctors and nurses were competent and knowledgeable about their treatment needs and that they were given a professional and efficient service. They told us that long term health conditions were well monitored and supported.

Patients reported that they felt that all the staff treated them with dignity and respect and told us the staff listened to them and were well informed.

Patients said the practice was very supportive and felt their views were valued by staff. They were complimentary about the appointments system and its ease of access and the flexibility provided.

Patients told us that the practice was clean and tidy.

Patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the GP patient survey showed that 94% of patients said that they had trust in the last GP they saw or spoke to.

Queens Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector, a second inspector and two specialist advisors (a GP and a practice manager).

Background to Queens Road Surgery

Queens Road surgery is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Queens road area of Halifax. The practice has three GPs, a management team, practice nurses and healthcare assistants, administrative staff and a cleaner.

The practice is open 8:00am to 6:30pm on Tuesday to Friday, late opening until 9:30pm on Mondays. Patients can book appointments in person, via the phone and online. Appointments can be booked in advance for the doctors and for the nursing clinics. When the practice is closed patients accessed the out of hours NHS 111 service.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The practice is part of NHS Calderdale CCG. It is responsible for providing primary care services to 6211 patients. The practice is meeting the needs of an increasingly ethnic minority patient list size that is generally comprised of an equal number of women and men.

Why we carried out this inspection

Queens Road surgery was part of a random sample of practices selected in the Calderdale CCG area as part of our comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

We carried out an announced 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 registered 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 in accordance with the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people

Detailed findings

- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through face-to-face interviews and via comment cards completed by patients of the practice in the two weeks prior to the inspection visit. We spoke with GPs, the practice manager, clinical nurses, health care practitioners, administrative staff, data quality manager and receptionists.

We observed how staff treated patients visiting and phoning the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service. We received 40 completed cards that were on the whole positive about the service experienced.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments received from patients that we spoke with. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Staff who identified an incident could talk to the practice manager or a GP and there was a reporting form to record this information. Incidents were prioritised so that urgent action could be taken if required, otherwise they were discussed at a monthly meeting where minutes were kept and actions managed.

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

We looked at the 'Serious Adverse Events/Significant Events/Incidents' log which included 11 entries. These were all well documented, action taken and learning was recorded. Examples included a medication error, vaccine fridge temperature anomaly and a new more effective system for dealing with urgent faxes from hospital.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred every week to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and the findings were disseminated to relevant staff, for example pull cords for the window blinds were adjusted to reduce the length to comply with new safety regulations. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. All GPs and practice nurse had attended level three safeguarding training; we noted they followed the local child protection protocols. There was a monthly meeting that considered safeguarding incidents with local social services teams.

We asked members of the 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 regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The lead GP told us that all clinical staff have attended CCG organised Safeguarding training held in the last two months. Other staff have also attended the relevant training. The two staff who had not been trained were to be scheduled to attend. The CCG contact for Safeguarding was aware of their training requirements. A training log was maintained for all staff. The Safeguarding policy had been updated and a list of contact details of Safeguarding services was in every clinician's room.

A GP explained to us a safeguarding case in which a child attended the surgery with pain and unexplained bruising, the guardian could not explain this. This child was already known to safeguarding team. The child underwent a child protection medical the next day by a paediatric consultant and was found to be consistent with an accident.

Clinicians locked away their blank prescriptions at the end of every day. Blank prescriptions were removed from the printer trays. They were responsible for their own prescriptions. Reception staff had been instructed to do the same. Chaperones were offered and they had two nurses and two reception and administration staff who were trained as chaperones. The practice had a poster in the reception area advertising this. The practice had a Chaperone policy.

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 for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Patients were routinely informed of common potential side effects at the time of starting a course of medication. The IT system allowed for 'on screen' messages which were discussed with the patient. Patients were also reassured of some rarity of side effects.

A nominated person (practice nurse) was responsible for emergency medication, equipment, infection control and record keeping.

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 nurse was also the practice lead for infection control and attended the Calderdale Council public health and infection control meetings regularly and gave regular feedback to the rest of the practice staff.

The practice had nurse leads 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 there after annual updates. We saw evidence the lead nurse had carried out audits for the last year and that any improvements identified for action were completed on time. The nurse referred to the CCG infection control policy on line, this enabled the latest policy to be followed at all times.

Hand hygiene techniques guidance was displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that 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 indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example vaccine fridge thermometers.

The practice nurse was responsible for maintaining emergency equipment and medicines. The practice nurse maintained a temperature log which also included the medicines fridge. There was a description and list of all emergency medicines that the practice kept on site.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting staff.

All staff recruited to the practice were interviewed and had references obtained before any job offer was made. The lead GP told us that they do not discriminate. New staff were subject to DBS checks and had a six month probationary period. They were also given an induction on starting and signed a confidentiality agreement. They were also given a copy of the Employee's handbook to read. The practice had also signed up to the yearly contract with 'Croner Consulting' for employment advice.

All staff had yearly appraisals. A medical appraisal is a key opportunity to focus on the professional development needs. A medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a GPs work. GPs had their own appraisals under the National Health Service England (NHSE) appraisal scheme and GMC Revalidation. Nurses were appraised by a GP who was also a GP Appraiser with NHSE. A GP appraised the practice manager. The practice manager appraised the reception manager and the administration staff.

Safe procedures were in place to ensure that criminal record checks via the disclosure and barring service (DBS) were undertaken where necessary. Risk assessments of all roles and responsibilities had been completed to determine the need for a criminal record check. Criminal record checks of staff employed within the practice, were repeated at three year intervals.

Good

Are services safe?

The reception manager appraised the reception staff. Personal development plans and training logs were kept.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Annual appraisals which the staff saw were conducted appropriately. The staff felt that their suggestions where possible were taken up at these appraisals. A recent e-learning on complaints was undertaken by all staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy, the practice manager took overall responsibility for health and safety matters. Health and safety information was displayed for staff to see.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and how to use it and records we saw confirmed these were checked regularly.

The practice had developed a comprehensive business continuity plan specifying the action to be taken in relation to a range of potential emergencies that could impact on the daily operation of the practice.

We examined the business continuity plan which was comprehensive and in line with other business continuity plans we had seen.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and care and treatment considered, in line with current legislation, standards and evidence-based guidance. We spoke with the GP who told us they used relevant and current evidence-based guidance such as the National Institute for Health and Care Excellence (NICE) guidelines. These were applied during assessment, diagnosis, referral to other services and management of long term conditions or chronic conditions such as hypertension.

QOF (quality and outcomes framework) was used to monitor the practices performance in the nationally agreed clinical and non-clinical domains. How the practice was performing was readily available on the IT system. In 2014-2015 the practice had achieved 512 (out of 559) points in the clinical domain which was a significant improvement over the previous year.

Yearly medicine management meetings with the CCG to improve and rationalise prescribing patterns were taking place. Action plans with audits to reduce antibiotic and hypnotics prescribing were currently being implemented. The practice were already aware of the high antibiotic and hypnotic usage before the CQC Intelligent Monitoring data publication. High prescribers were identified and action plans developed. Prescribing had improved significantly. Other targets included a reduction in the usage of diclofenac by switching to ibuprofen or naproxen.

As part of GP Appraisals, the practice undertook regular audits. This was also highlighted in the hypertension, UTI in men and heart failure audits.

Further monitoring had been agreed upon with the CCG and a new 'STOP-START' software package was due to be installed on prescriber's computers in May 2015. It would warn prescribers of various interactions with existing drugs when prescribing a new drug. This software had undergone a successful six month trial and would also provide audit trails for all prescriptions.

The GPs told us they lead in specialist clinical areas such as diabetes, hypertension and asthma and 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 prescribing of medication. Our review of the clinical meeting minutes confirmed this happened.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nurses showed that the culture in the practice was that 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 monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last year. These completed audits enabled the practice to demonstrate the changes resulting since the initial audit. The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. An example audit we looked at in detail was for antibiotics. The aim of the audit was to ensure that all patients prescribed antibiotics were being managed in the safest environment and reduced use of antibiotics was effectively being monitored and reported.

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

Effective staffing

Staff had the skills, knowledge, qualifications and experience to deliver effective care and treatment. Staff received appropriate training to meet their learning needs and to cover the scope of their work. Staff we spoke with

Good

Are services effective?

(for example, treatment is effective)

told us that newly employed staff were supported in the first few months of working in the practice. We were able to review staff training records and saw this covered areas such as safeguarding vulnerable adults and children.

Staff told us that they felt they had opportunities to develop and were able to take study leave and protected time to attend courses. Multi-disciplinary training and the open supportive culture were evident at this practice.

Working with colleagues and other services

The practice had clear arrangements in place for referrals to other services. Patients told us that they were given a choice of which hospital they would like to be referred to. It was the GPs responsibility to follow up on the referrals.

Staff worked together to assess and plan on-going care and treatment in a timely way when patients were discharged from hospital. We spoke with the practice manager who told us that discharge letters were scanned on to the patient's record (about half of the hospital letters were received electronically). This enabled the practice to have an effective means of ensuring continuity of care and treatment of those patients discharged from hospital. Their records from the hospital were scanned onto the patients' records so a clear history could be kept and an effective plan made.

Information sharing

Systems were in place for making referrals through the Choose and Book system. The Choose and Book system enabled patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital. The practice manager reported that this system was easy to use.

The practice manager told us that the practice had a commitment to care homes which it managed from a medical viewpoint. GPs visited as and when required.

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 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 and the Children's and Families Act 2014 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.

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 where possible. These care plans were reviewed annually or more frequently if changes in clinical circumstances required it. While talking with staff they 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 were used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Patient records remained confidential at all times. Access to them was only provided with patient's own consent. Information on the IT system records were only shared with other health care professionals if the patient agreed and they could withdraw consent at any time. Request for records from third parties e.g. solicitors and insurance companies had to be accompanied by signed written consent. All staff had confidentiality training organised by the Medical Protection Society on 27 Nov 2014. Consent to treatment policy had been updated recently.

Health promotion and prevention

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 there was a clear policy for following up non-attenders by the named practice nurse.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering 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 diabetes checks to patients and offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

There was a variety of information available for health promotion and prevention throughout the practice and in the waiting area. The practice had also displayed useful information for patients which was situated in the reception and waiting areas. Information on the PPG, NHS, dementia support memory club and Ebola. This provided a good service for patients to seek health promotion information and literature.

Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home.

The nurse we spoke with told us there were a number of services available for health promotion and prevention.

These included child immunisation, diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD), cervical screening and travel vaccination appointments.

The practice provided yearly flu clinics with posters and leaflets from the CCG/NHSE. They also offered pneumonia, travel clinics/immunisations, baby immunisations, baby clinics/health checks, shingles vaccination clinics, smoking cessation, cervical smear screening, pre-conceptual advice, family planning including long acting contraception (Depo & Implanon), minor Surgery clinics (joint injections), NHS Health Checks, over 75 health checks, maternity including post-natal checks, baby checks, Asthma, COPD, Diabetic clinics, phlebotomy services, weight management and healthy living and podiatry (in conjunction with diabetic) clinics.

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 GP patient survey tool and feedback from patients undertaken by the practice via the patient participation group. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the GP patient survey showed that 94% of patients who responded said that they had trust in the last GP they saw or spoke to. The practice was also above average 97% for its satisfaction scores on had confidence and trust in the last nurse they saw or spoke to.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 40 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 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 that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was shielded by partitions which helped keep patient information private.

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 evidence of learning taking place as staff meeting minutes showed issues had been discussed.

Patients were treated as individuals with dignity and respected at all times. There was respect for their privacy and confidentiality and the practice had a dedicated private interview room for their use on request. There were posters to this effect as well in the reception area. The practice was on the ground floor with disabled access as well as a disabled toilet.

Patients requesting confidentiality at the reception desk could also 'check-in' on the touch screen without fear of their personal details being overheard.

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 GP patient survey showed 75% of practice respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 74% felt the GP the last GP they saw or spoke to was good at giving them enough time. Both these results were comparable to this CCG area and national averages.

Patients we spoke with on the day of our inspection told us that 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.

Staff told us that translation services were available for patients who did not have English as a first language (75% Pakistani origin patients). We saw notices in the reception areas informing patients this service was available.

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. For example, this highlighted staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

Notices in the patient waiting room signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

A GP told us the practice always endeavoured to assist the patient to the best of their ability and 'go the extra mile' on occasion. A recent terminally ill patient on the palliative care pathway was also of Muslim faith where burial is required as soon as possible after death. The patient passed away on Saturday morning when only the out of hours services was available and there was no possibility of a death certificate until the following Monday. The GP was aware of his death and aware of the culture of the family. The GP provided the death certificate for the family that morning so that the burial could be performed that day. The family acknowledged that this was done above and beyond the call of duty and was very appreciative.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to translation services and staff who spoke other languages. The practice provided equality and diversity training. Staff we spoke with confirmed that they had read the 'Patient Dignity Policy' and that 'Equality & Diversity Policy' was discussed at staff appraisals and team events. The premises and services had been adapted to meet the needs of people with disabilities.

The practice staff were aware of the needs of more vulnerable patients who may not normally have easy and regular access to GP services, for example homeless or transient patients.

The practice manager told us they had a very large numbers of patients from different ethnic backgrounds, namely Pakistani, Eastern Europeans people and a small number of patients from other Ethnic minorities. Most of these patients could speak English but interpreting services were available if required.

As per local arrangements, the practice used the Kirklees Community Language Services to arrange interpreters for their patients. The practice had a mix of pre-booked, book on the day and online appointments. They also had urgent, sit and wait appointments for those who deemed themselves to be in need of urgent medical attention.

Access to the service

Appointments were available from 8am am to 6:30pm on weekdays. Multiple pre bookable appointments were available up to four weeks in advance.

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

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were happy with the appointment system. This ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice.

The practice utilised a telephone based system to organise appointments. The practice also catered for walk in cases for people who did not have access to a phone. Reception staff were the first point of contact for patients. They were trained to take demographic data and brief medical details. Patients may be offered a routine appointment, a same day or an urgent appointment.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for 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 an active patient participation group. The minutes of the last two meetings were shown to us. Suggestions were discussed and agreed before implementation. The practice also had a comments box for suggestions and criticisms. The practice had also evaluated comments from the Friends and Family Test responses and had updated them on the new practice website. The management team was currently looking at the comments on NHS Choices.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff are aware not to offer any medical advice.
The practice also offered extended evening surgery times from 6:30 until 9:30pm every Monday. Over the last winter period, the practice had also signed up with the CCG 'Winter Pressures Scheme' to offer an extra six appointments every day. In addition, the practice had signed up to the 'Pennine GP Alliance' (a GP Confederation) to offer Saturday afternoon appointments which was in addition to the Out Of Hours services. For everyone (not just the elderly), repeat prescriptions did not require a visit to the surgery.

Repeat prescription requests were taken with the re-order slip, in writing, by postal mail or fax with the majority using the local pharmacies of their choice to re-order. The practice aimed to issue repeat prescriptions in 24 hours (previously 48 hours). There were two pharmacies in the immediate vicinity (100 yards) of the surgery with a further six pharmacies within a half mile radius. Most of these pharmacies would offer home deliveries to the elderly. Patients and their family members who requested the flexibility of using different pharmacies often picked up prescriptions themselves. The practice did not take repeat requests over the telephone to minimise errors from different and varying pronunciation of medicine names.

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 for example leaflets in the waiting area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice manager responded to complaints offering the patient the option to come in and discuss the issue. The manager contacted the GP concerned and the item was discussed at team meetings. We looked at the summary of complaints which highlighted the category of the complaint, summary of the complaint, the outcome and the learning outcomes for the practice.

Following a recent staff meeting, the practice now followed the complaints procedures and always acknowledge complaints within three working days. The practice had updated the complaints leaflets advising patients how to complain. It was placed prominently on top of the front desk, glass partition in the waiting room together with the practice leaflet. It was part of an on-going improvement and with the impending CQC inspection; the practice had now devised a sequential log of all the complaints to allow for easy reference and presentation when called for.

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 were told details of the vision and practice values were part of the practice's business plan.

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

The staff team understood and shared the vision for the practice and the GP partners had agreed the strategic approach of the business, we saw evidence of documented planning which supported their decision making.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the IT system. All the policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The QOF data for this practice showed it was performing at the national standards of 93.9% as of March 2015 compared to 77% in March 2014. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain and improve outcomes.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that 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 reported that staff morale was very good.

Staff were welcome to make any comments or suggestions at staff meetings or in private. Grievances were heard fairly and in confidence. The practice had an updated whistleblowing policy. This was also to ensure that staff were fully supported when voicing any concerns.

The practice manager was the first port of call for any staffing issues including nurses. The practice manager would approach the doctors and senior partner for difficult or controversial issues.

Front line staff also rotated to the back office e.g. for prescriptions. Back office staff helped to cover the reception area. This ensured the skill mix and a shared understanding of each other's workload. Staff had handover meetings with different shifts. Staff used message books to note any problems, issues and comments.

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

The practice had gathered feedback from patients through annual patient surveys, suggestion box and complaints received. We looked at the results of the annual patient survey and were shown a report on comments from patients.

The practice had an established patient participation group (PPG) who contribute and feedback customer satisfaction. The practice has found these comments an extremely useful reflection tool for helping to improve customer service. Currently there were nine members.

The practice manager was working with the PPG to have broader representatives from various population groups; including people from ethnic backgrounds. A GP usually attended PPG meetings. The PPG met every quarter. Recent improvements made to the practice as a direct result of the PPG included an improved appointment system and investigating DNAs (do not attends).

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistle blowing policy which was available to all staff within the practice.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice offered all GPs and nurses time to develop their skills and competencies. Staff who we spoke with confirmed this study time was made available to them.

Systems were in place for recording and monitoring all staff training needs. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes.

The practice trained medical students: first, second and third years. A GP was an undergraduate tutor and appointed personal tutor for student doctors. Two GPs were also trained medical school student examiners for third and fourth year exams. A GP had achieved a University clinical excellence award for quality of teaching to medical students.