Wibsey and Queensbury Medical Practice

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 inspection at Wibsey and Queensbury Medical Practice on 11 February 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. 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. Data showed patients rated the practice higher than others for several aspects of care via the patient surveys. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible 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. The practice had adequate facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system.

Summary of findings

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 place to drive continuous improvement. Governance structures were in place and there was a robust system in place for managing risks.

The PPG engaged with patients during immunisation days and actively supported it membership to include people from all backgrounds. This level of engagement was outstanding.

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.

Older people accounted for around a fifth of the practice population. The practice worked with the community matron and district nursing team in managing the health and care of this population, in particular patients who were unable to attend the practice or who resided in a nursing or care home.

To avoid unplanned admissions the practice held a register of those patients who had been identified as being at higher risk of admission to hospital. The practice was working with the top two percent of patients, 179 in total, who all had a nominated GP and an agreed care plan to manage their care. The practice used the Risk Stratification Tool provided by the CCG to identify this group of people. All the patients identified on the register were reviewed at least every three months by the patient's allocated GP. Within this group of patients, any patients residing in a care/nursing home or sheltered accommodation who had attended or been admitted to hospital were discussed every month at the regular Monday practice meetings.

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.

All the patients with long term conditions such as asthma, chronic obstructive pulmonary disease, diabetes, heart failure were invited to at least an annual review. If a more frequent review was required the practice nurse would discuss this with the individual patient.

Summary of findings

The practice had set up a recall programme to try and ensure patients were recalled appropriately. During each review for the long term conditions the practice nurses completed the relevant templates specific for each condition.

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 were 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.

The practice provides antenatal care to expectant mothers, and for this group of patients they encouraged uptake of the Whooping cough vaccination. Weekly antenatal clinics were provided by the midwives within the practice locality.

Childhood immunisations were available and undertaken by the practice nurses. The GPs performed the six week child assessments. The health visiting team provided weekly clinics for pre-school age children at both surgeries. The current uptake for immunisations in the under two year old group was 99% and the pre-school uptake rate was 93%.

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.

To assist the practice population who were workers, students or recently retired they currently offered a number of early morning appointment bookable via the practice website. In addition they also offered appointments on a Saturday morning, to those patients who were unable to attend during normal working hours.

Summary of findings

The practice was currently working with public health, offering a NHS Health Check to those patients aged between 40 and 74 currently not identified as being on any clinical register, screening for cardiovascular risk and diabetes.

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.

The practice kept a register of people with learning difficulties living independently or in community group homes. They were all offered annual health checks. Another vulnerable group of people were those suffering from alcohol problems. A person is employed to work with people with alcohol problems.

The practice hosted a weekly session with a benefits advisor for patients requiring assistance with benefits and debts.

The practice undertook six to eight week review meetings with the health visitors to discuss any vulnerable children identified as being 'at risk'.

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.

The practice had recently undertaken 'searches' to better identify patients suffering from dementia and ensured they were coded appropriately on the computer database. This group of patients were reviewed annually.

The practice also kept a register of those patients with chronic enduring mental health problems. This was to ensure these patients had a comprehensive care plan for their mental health. They were also considered by the practice a vulnerable group who needed annual reviews for their physical health needs.

Summary of findings

What people who use the service say

We received three CQC comment cards and spoke with four patients on the day of our visit. 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 their long term health conditions were monitored and they felt well supported.

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

Patients said the practice was very supportive and felt that 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 always clean and tidy.

Findings from the 2014 National GP Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice which was better than other practices in the area.

Wibsey and Queensbury Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Wibsey and Queensbury Medical Practice

Wibsey and Queensbury Medical Practice is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury, maternity and midwifery services and diagnostic and screening procedures. It provides GP services for patients living in the Wibsey area of Bradford. The practice has six GPs, a management team, practice nurses and healthcare assistants, administrative staff and cleaners.

The practice is open 8am to 6pm on Monday to Friday with a weekend opening of 7am to 1:15pm on a Saturday. 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 was closed patients accessed the out of hours NHS 111 service.

The practice is part of NHS Bradford District CCG. It is responsible for providing primary care services to 11,124 patients. The female patient population of the practice makes up 50% of the practice population and 18% of all patients are over 65 years of age. The practice is meeting the needs of an increasingly elderly patient list size that is generally comprised of an equal number of women and men.

Why we carried out this inspection

Wibsey and Queensbury Medical Practice was part of a random sample of practices selected in the Bradford District CCG area as part of our new comprehensive inspection programme covering Clinical Commissioning Groups throughout the country.

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 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?

Detailed findings

- Is it well-led?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

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, assistant practice manager, clinical nurses, health care practitioners, administrative staff 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.

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. 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 saw there was an issues log kept for matters such as delayed discharge summaries and these were relayed via the clinical commissioning group (CCG) monthly meeting.

We reviewed safety records, 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.

The practice held an annual medication review for Polypharmacy. Polypharmacy is the concurrent use of multiple medications. The repeat prescribing system showed us that 66% of the older population had received a formal medication review during the past twelve months. The repeat prescribing system was safe as it would only allow 12 months of repeat prescriptions before having to be updated.

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 that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nurses were aware of the system for raising issues to be considered at the meetings.

We looked at a safeguarding incident dated October 2014. This was discussed in a GP meeting and disseminated to all staff.

An audit of aqueous cream usage was undertaken in April 2014. As a result a new policy of prescribing aqueous cream strictly for use as a soap substitute was instigated. After three months the practice carried out a prescribing analysis again. Results showed a significant reduction in the overall use of aqueous cream and a shift away from inappropriate prescriptions of aqueous cream amongst the GPs.

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. We asked members of the medical, nursing and administrative staff about their most recent training. A GP had attended level three safeguarding training; the practice nurse had level three; they follow the local child protection protocols. There was a monthly meeting that considered safeguarding incidents with local social services teams.

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 practice had named GP's and nurses appointed as leads in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

Chaperone training had been undertaken by all administration staff, including receptionists. The staff understood their responsibilities when acting as chaperones.

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?

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.

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

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 rarity of side effects.

Cleanliness and infection control

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

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and 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. We saw copies of completed audit visit report with a score of 99% given to the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and aprons were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

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 ophthalmoscopes, otoscopes, digital blood pressure monitor and the vaccine fridge thermometers.

Staffing and recruitment

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

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 they was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

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. 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.

The practice had CCTV with clear and visible signage explaining that recording of the premises was taking place to maintain safety for all staff and visitors to the practice.

Good

Are services safe?

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 which was 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. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

The practice had 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. Risks identified included incapacity of the GP partners and the loss of the computer and telephone systems. The document also contained emergency contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patient's 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 that 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.

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 that 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 and assistant 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. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been completed recently. 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 medication reviews. The aim of the audit was to ensure that all patients prescribed repeat medicine were being managed in the safest environment. The information was shared with GPs and patients were called for a medication review. A second clinical audit was completed later which demonstrated that all patients were receiving the recommended dose.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice had a system for the summary of care records. Just over ninety-eight percent of patients had their summary care records on the practice's IT system. The small percentage of patients 'records not on the system were for patients who had chosen to "opt out" and did not want their records on the system.

All new patients registering with the practice were asked if they wished to consent to their summary care records uploading. By having the records stored electronically the practice was able to safely manage and monitor outcomes for patients efficiently.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, all of 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.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they

Good

Are services effective?

(for example, treatment is effective)

reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

We were told about how the practice provided end of life care. The practice worked to the Gold Standard Framework with multi-disciplinary meetings held regularly. The named GP knew each of the families.

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 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 we saw that this covered areas such as safeguarding, health and safety, fire and first aid.

Staff had received an appraisal every year and the practice manager confirmed to us that all staff would receive an appraisal yearly. Staff told us they were able to discuss any issues or training needs with their manager.

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. We saw evidence of staff undertaking additional training in mental health. The practice last had a protected learning session dedicated to dementia in 2012 and this is an area they felt should be updated for staff.

A locum information sheet had been devised and compiled for induction of locums. We spoke with a GP on the day of the inspection and they explained to us how the induction process worked. The GP reported that they had effective back up and support from the practice. While locums were not been involved in the practice meetings they reported that effective communication of changes was done through the IT system. Any changes that were the result of significant events were also well communicated through this system and the practice manager. There was an effective open door policy and this enabled the locum to get suitable and timely advice when needed.

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 ongoing 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 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.

The practice had systems in place for managing blood results and recording information from other health care providers including discharge letters. The GP viewed all of the blood results and took action where needed.

The practice engaged with multidisciplinary case meetings. In addition to the quarterly review meeting for the patients on the practice Palliative Care Register, they also met monthly with several other practices in the locality. This involved five practices discussing the patients who were housebound, but required nursing/social support in addition to continued medical support. The meeting was attended by representatives from Carers Resource, District Nurses and Social Services to discuss how the practices could best improve the patient's health and wellbeing. Minutes of the last meeting of 29 January 2015 were shown to us.

We were shown evidence of multi-disciplinary team working/case management of patients with mental health problems. The practice regularly visited a large local Nursing Home, where there were a significant number of patients with dementia. The two GP's who visited the nursing home liaised with a Consultant in Psychiatry for the Elderly, about management of symptoms.

The practice worked closely with other social and health care providers. The practice had a weekly session provided by a finance expert to which the practice could directly refer patients.

Good

Are services effective?

(for example, treatment is effective)

The practice manager was involved with a group of GP practices which met once a quarter to discuss and manage common themes in practices in the area.

Information sharing

Systems were in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will 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 had a commitment to the four care homes which it managed from a medical viewpoint. GPs visited as and when required. There were structured templates for each of the patients and the information was also cascaded to the out of hours provider who could usually see the practices IT system notes but who also received faxed copies of special notes for each of these patients where appropriate. This demonstrated a good level of communications with other providers.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. We saw a copy of a 'Good Practice' data quality toolkit dated 1 April 2014.

The practice also actively monitored 'Do Not Attend' information on the practices notice boards. This display of information was helping to reduce the number of missed appointments.

Consent to care and treatment

We found that 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. 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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice has a provision of named GP for patients aged 75 and over. The practice has written to all patients aged 75 and over, informing them of their named GP. They regularly checked for patients who reach the age of 75 and write to them, again informing them of their named GP. The practice currently had 868 patients aged 75 and over and all patients had been written to informing them of their named GP.

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 practice had written to all those patients eligible for the Zostavax vaccine. The letter explained the benefits of receiving the vaccination. During the flu campaign the practice encouraged all patients aged 65 and above to receive the flu vaccine. The practice opportunistically offered the pneumococcal vaccination throughout the year to patients.

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, 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.

The nurse we spoke with us 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.

Population Groups evidence

Older people – There were 1994 registered patients

• A Register was kept of patients who are identified as being at high risk of admission / End of Life and have up to date care plans and sharing with other providers

• 66% of people received structured annual medication reviews for polypharmacy

• 31% of people had been offered Cognition Testing (as documented in the notes)

• All patients over the age of 75 had a named GP

People with long term conditions – 2247 registered patients

- 82.5% Diabetics had an annual foot check and eye check

• 98.3% Adoption rate of Summary Care records on the practice's IT system

• 179 patients had a named GP

Families, children and young people (0-17 population 2276 registered patients)

• Almost all children (99%) under the age of two and 93% of pre-school children had had the standard immunisations.

Working age people – 6654 registered patients

• There was a 25% uptake rate for Health Checks

• There was a 79.5% uptake rate for Cervical smears

• 88.7% people had Blood pressure checks

People whose circumstances may make them vulnerable (50 patients on Learning Disability Register)

• 50 patients recorded on the learning disability register. Practice holds a register of those in various vulnerable groups (e.g. homeless, travellers, learning disabilities)

• 50% of patients with learning disabilities received an annual follow-up

People experiencing poor mental health – 117 registered patients

• 81.8 % of people with severe mental health problems had an annual physical health check

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 92% of patients said that their last appointment was convenient for them. The practice was also above average, 93%, 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 three 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 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 she 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.

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 88% of practice respondents said the GP listened to patients and 85% felt the GP was good at explaining treatment and results. 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. 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. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room also 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.

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. The practice had committed a lot of time and effort into responding to fluctuations of demand.

There had been very little turnover of staff during the last ten years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local nursing and residential care homes by a named GP. The result of this was seen in the reduced need for unplanned call-outs and reductions in unplanned admissions to hospital. The practice had achieved and implemented the gold standard framework for end of life care.

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 GPs 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 the 'Equality and 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. This included lowered reception windows for wheel chair users at the reception desk.

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 had a stable register of patients. The practice manager told us they had very small numbers of patients from different ethnic backgrounds, namely 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. The practice had a hearing loop system in place for use by patients with hearing difficulties.

Access to the service

Appointments were available from 8am to 6:30pm on weekdays. Multiple pre bookable appointments were available up to two weeks in advance. No one was turned away.

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 and 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.

Patients could book directly into nurse appointments or they may be contacted by reception to book appointments for chronic disease management. The nurses had recently started to provide a telephone follow up service for chronic disease management which was proving popular with patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us that when they needed urgent attention they were able to see a GP on the same day.

The practice was situated on the ground of the building with all of services for patients on the ground floor

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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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. 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 the weekly Friday team meeting. We looked at the summary of complaints from January 2014 to January 2015 which highlighted the category of the complaint, summary of the complaint, the outcome and the learning outcomes for the practice.

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. These values were at the heart of the practice's way of providing services to patients.

We spoke with members of staff and they all 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.

The GP told us that due to planned contractual changes the practice had formed a federation with nine other practices. We were told that due to financial stresses on general practice they had formed a federation with other practices in order to both remain financially viable and to assure the quality of care provided.

We discussed the agenda of an away day to be held in April 2015 and saw that staff would be discussing the team strengths and aspirations for the future.

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 their performance. The QOF data for this practice showed it was performing above the national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain and improve outcomes.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of legionella bacteria. All risk assessments had been recently reviewed and updated.

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 the senior 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 GPs fulfilled a leadership role within the practice, providing highly visible, accessible and effective support.

The practice had implemented a comprehensive schedule of meetings which provided staff with the opportunity to discuss concerns and disseminate information. Staff told us that there was an open and transparent culture within the practice. They had the opportunity to contribute to the agenda of team meetings, to raise issues within team meetings and on a more informal basis and felt well supported in doing so.

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

The practice had gathered feedback from patients through annual patient surveys, comment cards, 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 since August 2011 who contributed and feedback customer satisfaction. The practice had found these comments an extremely useful reflection tool for helping to improve customer service. Currently there were 14 members.

The practice manager was working with the patient participation group (PPG) to have broader representation from various population groups; including people from

Are services well-led?

Good

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

minority ethnic backgrounds. A GP always attended every PPG meeting. The PPG met every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG.

Recent improvements made to the practice as a direct result of the PPG included use of hand gel, improved appointment system, use of the pharmacy and financial support via a debt advisory service.

There was a good response rate from this year's PPG survey which was sent out to a sample of patients.

Positive Findings included:-

- 94% think the written information they receive at the surgery is easy to understand.
- 80% find the access into the building very easy.
- 78% find it easy to find their way around the practice.
- 84% find the surgery very clean this was an increase of 11%
- 89% are satisfied or very satisfied with the service they get from their GP
- 88% are satisfied or very satisfied with the service they get from their Practice Nurse
- 88% are satisfied or very satisfied with the service they get from the reception staff

The practice had gathered feedback from staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw minutes of a meeting where improvements were discussed and an action was agreed by all staff.

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

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 two 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 protected time to develop their skills and competencies. Staff who we spoke with confirmed this protected time was available. Staff also told us they were actively encouraged to take study time.

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 completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Significant events and incidents were discussed within weekly clinical meetings, GP partner meetings and monthly practice staff meetings.