Cowgill 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 Cowgill Surgery on 24 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services was available and easy to understand.
- Patients said they found the appointment system very accessible.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Evidence from data and discussions with patients showed patients rated this practice highly in all aspects of their care. They said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population when developing service. They engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Evidence from data and discussions with patients showed patients were highly satisfied with the appointments system in place. For example, results from the national GP survey showed 100% of respondents described their experience of making an appointment as good. The practice had

Summary of findings

good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available on the website and easy to understand. Evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

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

Whilst the GPs and practice manager had a clear vison for the practice and there had been substantial investment in the practice but there was no business, financial or development plan available.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits. Regular visits to local nursing homes were also undertaken. Monthly multi-disciplinary meetings were held to review the care needs of older people. The practice worked closely with other health and social care organisations such as the integrated care team and ran a number of in-house clinics.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified and monitored. Home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to monitor patient outcomes and to deliver a multidisciplinary package of care. An advanced nurse practitioner had been employed to support patients with complex needs. The practice held a number of in-house clinics to support this group of patients such as warfarin monitoring and in house electrocardiogram (ECG) appointments.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances who were at risk, Appointments were available outside of school hours and the premises were suitable for children and babies. The practice worked closely with other agencies such as the health visitors and held a number of in-house health and social care clinics. The practice provided care for a local college and had a good understanding of the particular need of this group. They provided flexible services to ensure the cultural and religious needs of this group were met.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The services offered ensured appointments were accessible, flexible and offered continuity of care. Drop in GP sessions, telephone consultations and pre-bookable early morning appointments were all available to this group of patients.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. A number of specialist clinics were also available in-house.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments for people with a learning disability.

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

The practice held a number of in-house health and social care clinics to support patients such as, health trainer clinics.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health received an annual physical health check and longer appointments were available. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out pre-screening and care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and held in-house clinics.

Summary of findings

What people who use the service say

We received 44 CQC patient 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.

Patients told us they were very satisfied with the service they received. They described the service as fantastic, very good, excellent and top quality. A number of comments described the doctors, nurses and reception staff as patient, caring, helpful and respectful.

The patients were complimentary about the care provided by the clinical staff. They told us the staff listened to them, explained treatments to them and involved them in decisions about their care. Patients described how well supported they were with their long term health conditions and they said they had been offered regular health checks.

Patients told us all the staff treated them with dignity and respect

Patients told us they really liked the open appointment system and were against any changes to this. They said the system offered them flexibility and they knew they could always be seen on the same day which they found reassuring. A small number said waiting times were too long.

Patients told us there had been a number of changes to the practice and the building had been completely renovated. There were some negative comments about the new waiting area now being too small and they said, sometimes, there was standing room only. They also said the new automatic door, to enable easy access for those with mobility problems, stayed open too long and it was very cold in the waiting area.

Patients said the practice was always clean and tidy.

We received information from the National Patient Survey. The information from the 2013 GP Patient Surveys showed 272 surveys were sent out and 101 patients responded. The results showed the practice scored better than national average in a number of areas and 99% rated their overall experience of this surgery as very (87%) or fairly good.

Cowgill Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP and a practice manager specialist advisor.

Background to Cowgill Surgery

Cowgill Surgery is situated within a purpose built surgery in Bradford.

The practice provides Personal Medical Services (PMS) for 3988 patients under a contract with NHS Bradford Districts Clinical Commissioning Group (CCG).

There are two GP partners, male and female, although one has recently retired and the practice manager is also a partner. There are also three salaried GPs, one male and two female. The clinical team includes a team of two practice nurses and a phlebotomist. An experienced team of management, administrative and reception staff support the practice. This practice is part of a group of four practices who share administration functions and the administration team were undergoing changes to their roles at the time of the inspection.

The practice opening times are Monday to Friday 8 am to 6 pm and there are extended opening hours on a Friday morning from 7am to 8.00am. Pre-bookable appointments with a GP were only available for the extended hour's appointments on Friday mornings. The other GP surgeries ran as drop in sessions between 8.00 am to 10.00 am and 3 pm to 5.30 pm.

Local Care Direct provides services between 6 pm and 6.30 pm and is accessed via the practice telephone number.

Calls to the practice are automatically redirected to this service outside of the practice opening hours. Between 6.30 pm and 8 am out of hours services were accessible by calling 111.

The practice is registered to provide the following regulated activities; family planning, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

Why we carried out this inspection

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

Please note when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at the time.

How we carried out this inspection

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

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

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

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

We carried out an announced visit on 24 February 2015. During our visit we spoke with a range of staff including a GP partner and the practice manager partner. We also spoke with three other GPs, a practice nurse, a visiting palliative care nurse, the practice pharmacist, head of patient services and three reception and administration staff. We also spoke with four patients who used the practice.

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 44 CQC patient comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. These included, reported incidents, national patient safety alerts, clinical audits, comments and complaints received from patients. The practice had processes in place to ensure incidents would be reported, recorded and investigated. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw records which showed the practice had managed incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff, including receptionists, administrators and nursing staff, knew how to raise issues for discussion at the practice meetings.

The practice manager showed us the system they used to manage and monitor incidents. We looked at the records of incidents and saw records were completed in a comprehensive and timely manner and records of action taken were also maintained. A log of significant events, outcomes and actions taken was available to the staff. Significant events were reviewed during a weekly multidisciplinary meeting and non-clinical issues were discussed at the weekly staff meetings. There was evidence the practice had learned from these events and the findings were shared with relevant staff. We saw from the significant event log action had been taken in response to incidents to minimise the risk of reoccurrence. For example, we saw procedures had been reviewed and updated as necessary and additional training had been provided to staff as appropriate. We looked at two incidents in detail and saw actions taken were appropriate in each case.

Where patients had been affected by something that had gone wrong we saw, where applicable, action had been taken to protect patient's health and welfare and an apology was given.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed the majority of staff had received training in safeguarding both adults and children at a level commensurate with role. A GP we spoke with told us the clinical staff undertake level 3 training and administration staff completed level 1. Staff told us they accessed training via an ELearning package and additional training was provided during their protected learning time and during in-house sessions. They told us specific training was provided for both safeguarding adults and children. Staff we spoke with were aware of their responsibilities and knew how to share information of concern. Safeguarding policies and procedures and the contact details of relevant agencies were available and accessible for all staff.

The practice had a designated lead GP in safeguarding vulnerable adults and children. They confirmed they had completed training at the appropriate level for this role (level 3). Staff we spoke with were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

The practice held monthly safeguarding meetings with other agency staff, such as the health visitor, to discuss concerns and share information about children registered at the practice. A system was in place on the practice's electronic patient records to highlight children at risk.

A system was also in place to highlight vulnerable adult patients. Vulnerable adults who may be at risk were reviewed at the monthly multi-disciplinary meeting held by the practice.

Information was provided to patients about safeguarding adults and children and where to refer any concerns they may have.

There was a chaperone policy and procedure in place. Information for patients which related to the provision of chaperones was displayed in the practice. We observed this document did not instruct staff who were chaperoning to stand inside a privacy curtain. This action is necessary to ensure staff could observe any procedures were carried out in an appropriate manner. The nursing staff usually acted as chaperones when necessary and they had the appropriate recruitment checks to enable them to

undertake this role if required. Staff we spoke with had a good understanding of the specific chaperone procedures required relating to a specific patient population group they provided services for.

Medicines management

Medicines were kept in a secure storage area, which could only be accessed by clinical staff. We saw dedicated fridges were used to store medicines which required refrigeration. Logs of the daily checks of the temperature of fridges had been maintained which showed these were within the recommended temperature ranges for the medicines stored. A protocol was readily available to staff to advise them on the action to take in the event of the fridge temperatures being outside of these recommended ranges.

We saw medicines for use in emergencies were accessible to staff. We saw these medicines were in date and were routinely checked.

Requests for repeat prescriptions were taken by e-mail, online, post, via the local pharmacy or at the reception desk. Repeat prescriptions were signed by a GP and checks were made to ensure the correct person was given the prescription. There were procedures in place for GP reviews to monitor patients on long term medicine therapy.

The practice employed a pharmacist who visited the practice once a fortnight. They assisted with monitoring the practice performance towards key prescribing performance indicators (KPPI) and they completed medication audits. For example, where alerts were received about medicines the pharmacist conducted an audit of patients who received the medicine and the GP then reviewed this to establish if any changes were required. The pharmacist also completed ongoing audits of antibiotic prescribing practice and clinical staff were informed of the outcomes at meetings. They told us they had seen improvements in antibiotic prescribing practice since the implementation of this system.

Any changes in guidance about medicines were communicated to clinical staff by the practice manager. The information was then discussed with staff at meetings.

Cleanliness and infection control

We observed the premises to be clean and tidy throughout. 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.

All staff received induction training about infection control specific to their role and received annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

The practice had a policy for the management, testing and investigation of legionella (A bacterium found in the environment which can contaminate water systems in buildings). We saw records confirmed the practice carried out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. We saw equipment maintenance logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers which indicated the last testing date. A schedule of testing was in place.

Staff we spoke with were aware of how to access equipment in an emergency and we observed emergency equipment was easily accessible to staff.

Staffing and recruitment

The practice was part of a group of four practices who shared some procedures and tasks in areas such as administration and human resources (HR). Senior administration staff and GPs worked across the four sites.

Good

Are services safe?

The GPs main recruitment files were held at another practice which was the site for the main HR functions. GP recruitment files held at this site were inspected during a CQC inspection in the same inspection period and were found to be complete.

The practice had recruitment policies and procedures. The documents identified the checks required for recruitment of clinical and non-clinical staff and the process to be followed to obtain these checks. For example, it included the type of proof of identification required, number of references, checking registration with the appropriate professional body and the criteria for criminal records checks through the Disclosure and Barring Service (DBS). We saw relevant checks were in place in all of the staff files we reviewed and basic information was available at the practice for one of the GPs who worked at the site on the day of the inspection.

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 a need for an additional GP had been identified and action had been taken to implement the additional sessions. There was an arrangement in place for members of staff, which included nursing and administrative staff, to cover each other's annual leave. A GP described how they ensured there was sufficient cover to provide appointments for patients and the processes in place to manage annual leave. They told us they rarely used locum GPs and were usually able to cover leave and other absence through the group practice arrangements. An information pack related to the main policies and procedures, contact details and local referral methods was in place for GPs who provided cover.

We saw there were changes in progress in relation to the organisational structure for administration and management staff due to the four practices in the group centralising some functions. Staff felt well supported and had been informed of the changes. Staff across the four practices had the opportunity to meet together and share training which they felt was beneficial. They had also maintained individual practice meetings.

We received positive comments about the staff from patients and patients told us they found all the staff to be caring and helpful. Patients also told us they liked the open appointment system and confirmed they were offered a choice of GP. A male and female GP were usually on duty.

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.

Risks were assessed and actions to reduce and manage the risk were recorded. For example, we saw health and safety and fire risk assessments had been completed and action plans were in place to ensure any shortfalls were addressed. Staff had completed health and safety and fire safety training and regular checks of fire equipment was completed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. We saw emergency equipment was accessible to staff, this included access to oxygen and an automated external defibrillator.

Emergency medicines were available in a secure area of the practice and staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included contact numbers for services such as water, gas and electricity and included guidance for staff in the event of a major incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE), local commissioners and in-house protocols and templates. We were told templates were developed to ensure best practice was implemented and each patient received support to achieve the best health outcome for them. A GP said the templates and protocols provided aide-memoires for less experienced clinicians. We were shown examples of some templates available such as a template for diabetes and another for palliative care.

We were told the GPs had lead roles in clinical areas and clinicians provided specialist clinics across the four practices in the group. For example, the group of practices had a GP with special interests (GPwSI) in diabetes and gastroenterology and they had employed a nurse specialist in heart failure. They also had a practice nurse and advanced nurse practitioner with interests in asthma and chronic obstructive pulmonary disease (COPD). They provided specialist clinics and care for patients with long term conditions.

Clinical staff we spoke with told us they were well supported and said they shared information and felt able to ask colleagues for advice and support.

The data from the local Clinical Commission Group (CCG) which related to the practice's performance for antibiotic prescribing was better than similar practices. The practice employed a pharmacist to ensure best prescribing practice and they carried out audits to monitor prescribing patterns.

The GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. Administration staff were able to describe the process which ensured urgent referrals were managed effectively and had been processed.

The practice had improved systems for diagnosing dementia. They told us they had identified they were low at identifying and diagnoses of dementia in comparison to other practices. As a result clinicians attended a learning event which discussed dementia as well as how practices could become a 'dementia friendly practice'. They said they had also invited the CCG and dementia lead to a multidisciplinary team meeting to go through all processes and pathways available on the electronic patient record and elsewhere. They told us this resulted in the practice improving their rates of newly diagnosed dementia patients and enabled them to implement a package of care.

Interviews with GPs showed the culture in the practice was that patient's clinical need was the basis for care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in how they monitored and improved outcomes for patients. These roles included data input, scheduled clinical reviews, and how they managed child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits and other improvements to the service. National data such as Quality and Outcomes Frame work (QOF) showed the practice performed well in all areas. The most recent data available to us showed the practice had achieved 99.1% of the available QOF points.

The practice used a proactive care planning approach to minimise the risk of patients being admitted to hospital. The practice used software tools and the clinician's knowledge of patients to identify individuals at high risk of admission to hospital. They also identified those patients in at risk groups, which included those with dementia, advanced chronic obstructive pulmonary disease (COPD), heart failure and Parkinson's disease. Care plans were in place to minimise the risk of unplanned admissions for these patients and these were reviewed by named GPs every 3 months. To ensure a tailored plan for the individual the care plans were developed following one to one contact with the patient and /or relatives and a multidisciplinary meeting. A nurse had the specific role of identifying and contacting patients who had an unplanned admission. Patients with complex needs or a recent unplanned admission were reviewed at weekly multidisciplinary meetings and action plans were developed to reduce future risk of unplanned admissions. A practice learning event had been held to develop this care planning approach.

Good

Are services effective?

(for example, treatment is effective)

We saw clinical audits were linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). We saw results of audits were regularly reviewed. We looked at two audits in detail. These showed prescribing practices had improved and performance had been sustained over time. For example, following changes in NICE guidance which related to a specific medicine they had identified patients who were prescribed the medicine and had reviewed their circumstances. They had written to the patients, explained the changes and invited them for a review to discuss this. A review of the audit showed the changes had been implemented. We saw results of audits were shared with staff via email and at multidisciplinary meetings.

We saw information which related to prescribing data for the practice. This information showed patterns of antibiotic, hypnotics, sedatives and anti-psychotics prescribed within the practice were within or better than expected levels. To assist them to monitor prescribing practice they employed a pharmacist. The pharmacist completed regular audits against key performance prescribing indicators. For example, the pharmacist completed a monthly audit to monitor prescribing trends of antibiotics by individual GPs in the practice. The audits mirrored the local and national initiatives to reduce prescribing of medicines which commonly show multi-organism resistance. There was a protocol for repeat prescribing which was in line with national guidance. In line with this, systems were in place to ensure patients receiving repeat prescriptions had been reviewed by the GP.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes, asthma, COPD and mental health. They were above the national average for recording alcohol consumption and smoking status for some groups of patients. They were above the national average for performing cervical smears and recording patients' blood pressure for at risk groups.

An advanced nurse practitioner, specialist nurses and a practice nurse had been employed within the group to support patients with complex needs. The practice held a number of in-house clinics to support patients such as warfarin monitoring, level 2 diabetes clinics and in house electrocardiogram (ECG) appointments.

The practice was working towards Gold Standards Framework Accreditation for palliative care. They had implemented systems on how they recorded end of life care needs and initiated monthly multidisciplinary palliative care meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw the majority of staff were up to date with essential training courses such as annual basic life support, fire safety and safeguarding adults and children.

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

All staff undertook annual appraisals which identified learning needs from which action plans were documented.

Practice nurses and health care assistants were expected to perform defined duties and they were trained to fulfil these duties. Clinical staff told us they were well supported and said there were plenty of opportunities for clinical support and training. Non-clinical staff also told us they were well supported and had access to training relevant to their role.

We saw from the staff rota the same two or three GPs were on duty at any one time and this provided continuity for patients. However some GPs only worked one session per week. On discussion with a GP who worked on this basis we found they were not familiar with some aspects of the ongoing management of the practice. For example, they were not familiar with outcomes of audits and did not attend the practice meetings as they were based at another surgery in the group. However they were aware of the staff that held lead roles and who to report issues to such as safeguarding concerns.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers and held regular multi-disciplinary meetings to monitor patients at risk; review patient's needs and manage complex cases. We saw health professionals, which included health visitors and palliative care and community nurses, were invited and attended these meetings.

We spoke to a visiting health professional and they told us they had good communication with the practice. They said the GPs were very accessible and they could discuss patient care with them at any point.

The practice had systems in place to monitor if patients attended appointments where they had been referred by the practice to secondary care services such as the hospital. Where the practice was informed the patients had not attended an appointment they would follow this up with the patient.

Procedures were in place to manage information from other services such as the hospital or out of hour's services. Staff were aware of their responsibilities when they processed discharge letters and test results. There were systems in place for these to be reviewed and acted upon where necessary by clinical staff.

Information sharing

The patient record system used in the practice and that used by the partner agencies, such as district nurses, was a shared system. We saw evidence of the systems in place to transfer information about patients care needs to out of hour's services.

Information about patients' needs was also shared, where required, at regular multidisciplinary meetings held in the practice. A GP and practice manager carer's resource representative, social workers, a psycho-geriatrician, district nurses, community matrons and voluntary sector organisations such as the Alzheimer's committee were involved. The purpose of these meetings was to discuss problems encountered by those patients who were vulnerable or had several long term conditions and to look at ways of improving service delivery and patient care.

Electronic systems were in place for making referrals, and in consultation with the patients, referrals were made 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 had systems to provide staff with the information they needed. Staff used the electronic patient record to coordinate, document and manage patients' care and policies and procedures were also available electronically. Regular practice meetings were held for staff and we saw from the minutes, agenda items included information about changes to policies and procedures, training opportunities and learning points from complaints and incidents.

Consent to care and treatment

We found GPs were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We did not see any evidence on the training log that training in this area had been provided. However the clinical staff we spoke with understood the key parts of the legislation. They also demonstrated an understanding of the assessment procedures to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Staff were able to demonstrate use of electronic templates such as a template for the Gillick competency test to assist them in this area. This test is 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 had numerous ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, chronic disease or mental health problem and these patients were offered an annual physical health check.

The practice offered NHS Health Checks and were involved in the 'Bradford Healthy Hearts' programme which is aimed at reducing the risk of stroke and heart attack for people in risk groups. They had also implemented the Diabetes 9 Care Process within the practice. The National Institute for Health and Clinical Excellence (NICE) recommends all people with diabetes should receive nine key tests at their annual diabetes review. These important markers ensure diabetes is well controlled and are designed to prevent long-term complications. The key tests included: weight, blood pressure, smoking status, eye examinations and foot examinations.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Data showed they were above the local clinical commissioning group (CCG) average on the uptake of immunisations in a number of areas.

The practice web site provided access to a wide range of patient information and links to other websites such as the local CCG self-care web page where four virtual self-care packs had been developed for dementia, heart failure, asthma and COPD. There were also links to the NHS choices web site where patients could access information such as healthy living advice for families and advice for people with long term conditions and minor illnesses. The pages on the practice web site could be easily translated by patients into different languages.

Additional clinics and services were available for patients within the practice. Working within a larger group of practices enabled access for patients to in-house expertise in cardiology, dermatology, diabetes, women's health, dementia, and gastroenterology. Clinics to improve health education were provided such as dyspepsia clinics and atrial fibrillation clinics. Patients could also access community diagnostics services within the practice such as echocardiograms (ECG), spirometry, anticoagulation and hearing tests.

The practice worked with other providers such as Carers Resource, Piccadilly Project, Gateway Counsellor services and Health Trainers to improve health outcomes for patients and staff attended community education events.

A range of health information leaflets were displayed in the practice waiting area.

Patients we spoke with were very complimentary about the level of information they received about their treatments during consultations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey where, from 272 surveys, 101 responses were received. Responses showed the patients rated the practice highly in all areas. For example, data from the national patient survey showed 99% of patients rated the practice as very good or fairly good. The practice scored above 95% for the GPs and the nurses being good at giving patients enough time and for the GPs and nurses being good at listening to them. Patients also said the last GP they saw or spoke to was good at treating them with care and concern and the practice scored 89% in this area.

Patients completed CQC patient comment cards to tell us what they thought about the practice. We received 44 completed cards which were very positive about their experience of the service. We also spoke with four patients on the day of our inspection. Patients said they were very satisfied with the service they received. They described the service as fantastic, very good, excellent and top quality. A number of comments described the doctors, nurses and reception staff as patient, caring, helpful and respectful. Patients told us all the staff treated them with dignity and respect

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

We saw staff were careful to follow the practice's confidentiality policy when they discussed patients' treatments so confidential information was kept private. The practice switchboard was located behind the reception desk and although a privacy screen was not provided a radio played in the waiting area which masked conversations. A side room was available for patients who wished to speak privately to reception staff. Records showed staff had received information governance and customer care training.

We found the practice staff were familiar with and respectful to the needs of a specific population group at the practice. They provided suitable arrangement's for these patients to be chaperoned where necessary and to see a GP of a specific gender. They also provided a private area for these patients to enable them to meet their religious needs.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and who completed CQC patient comment cards were complimentary about the care provided by the clinical staff. They told us the GPs listened to them, explained treatments to them and involved them in decisions about their care. The patients scored the GPs highly in the national GP survey in this area. For example, 98% of patients said they had confidence and trust in the last GP they saw or spoke to, 91% said the GP was good at explaining tests and treatments and 89% said they were good at involving them in decisions about their care.

We also received very positive comments about the nurses and we were told the nurses were very understanding and supportive. The nurse also scored highly in the national GP survey. For example, 99% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments, 96% said the nurse was good at involving them in decisions about their care and 97% said they were good at treating them with care and concern.

Patients said their long term health conditions were monitored and they said they felt very well supported.

We were told care plans had been produced for patients in high risk groups and for those with complex needs, this included those with mental health needs and those patients at high risk of admission to hospital.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting rooms and on the patient website informed patients how to access a number of support groups and organisations.

Good

Are services caring?

The practice identified carers on the electronic patient record system and offered them health checks as part of the care planning process. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice web site had information and links to Bradford and Airedale Carers Resource information and NHS carers direct.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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 in the way services were delivered. As a group of four practices who worked together, they continually looked to improve patient services and they utilised staff knowledge and skills to provide a number of in-house clinics for patients. Following a recent survey they had installed a lowered reception desk to ease access for wheelchair users. The practice told us they engaged regularly with the local Clinical Commissioning Group (CCG) and they had worked with them to improve their assessment processes for people with dementia.

A record of vulnerable patients such as those with learning disabilities and mental ill health was maintained and regular health checks were provided.

The practice provided a service to a specific group of patients who lived in the local community and staff had a good understanding of their cultural and religious needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had systems in place which alerted staff to patients with specific needs who may require assistance when they visited the practice. For example, we saw they had identified patients with visual impairment who may require assistance to access the practice. Home visits were offered to patients who were unable to visit the practice and to those patients who lived in local nursing homes.

The practice was situated within a building which was purpose built. The patient areas were on the ground floor and the patient areas were sufficiently spacious for a wheelchair user. Toilets with baby changing equipment and equipment suitable for those with a disability were available. A parking bay was provided outside the front entrance for patients with a disability.

The practice had just completed a period of building works to improve the practice and provide additional surgery space. The extensions to surgery space had been created by using some of the waiting room area and we received a small number of comments about the lack of seating and space available at very busy periods. They had also fitted electronic doors to improve access for people with a disability. However we also received a small number of comments about the doors staying open too long causing the waiting area to become very cold. The practice manager told us they would monitor this situation.

Fact sheets were available in different languages on the practice website to explain the role of UK health services and the National Health Service (NHS), to newly-arrived individuals seeking asylum. They covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services. The web site also had a translate page function so patients could view the website in a language of their choice.

Staff told us where patients attended who did not have English as a first language they usually brought an interpreter with them. We were also told two members of staff were multi lingual and supported patients as required. Translation services were available via telephone using language line.

Access to the service

The practice opening times were Monday to Friday 8 am to 6 pm and there were extended opening hours on a Friday morning from 7am to 8.00am. Pre-bookable appointments with a GP were only available for the extended hour's appointments on Friday mornings. The other GP surgeries ran as drop in sessions between 8.00 am to 10.30 am and 3 pm to 6 pm with the last patient requested to arrive half an hour before the session finished. Patients could also request a same day telephone consultation. A requirement for additional sessions had been identified by the practice and these had been provided.

We reviewed the most recent data available for the practice on patient satisfaction with the appointment system. This included information from the national patient survey. This indicated the patients were highly satisfied with the appointments system at the practice. For example, results showed 100% of respondents described their experience of making an appointment as good, were satisfied with the surgery's opening hours, found it easy to get through to this surgery by phone, found the receptionists at this surgery helpful and say the last appointment they got was convenient . The data also showed 92% of respondents

Good

Are services responsive to people's needs?

(for example, to feedback?)

with a preferred GP usually got to see or speak to that GP, 98% were able to get an appointment to see or speak to someone the last time they tried and 93% felt they don't normally have to wait too long to be seen.

Patients we spoke with told us they liked the open access surgeries because they knew they could always be seen when they needed to be. They told us they were always given choice of who they could see and they said they didn't usually have to wait too long to be seen.

Comprehensive information about appointments was available to patients on the practice website. This included information about which GP was on duty and information about home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, their call would be diverted between 6pm and 6.30pm otherwise an answerphone message gave the telephone number they should ring depending on their circumstances.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system on the web site and complaints information was displayed in the waiting area which included details on how to escalate a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had needed to make a complaint about the practice.

We looked at how complaints received by the practice in the last 12 months had been managed. The records showed complaints had been dealt with in a timely way although the initial response had not always been sent out within three working days. Patients had received a response which detailed the outcomes of the investigations. We also saw an apology had been given to patients where appropriate. Information on how to escalate their complaint if they were not satisfied with the response was included in the practice information leaflet but was not provided to patient's in the response to a complaint.

We found from records and discussions with staff learning from complaints had been shared with them.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had developed a statement of purpose which included their aims and objectives and a summary of these were displayed on the practice website. The practice aims and objectives included the aim to deliver excellent, confidential, accessible healthcare to every patient in a timely, effective manner.

Our discussions with staff and patients indicated the vison and values were embedded within the culture of the practice. Staff told us the practice was patient focused and they told us the staff group were well supported.

Governance arrangements

The practice was working together with three other practices and they were in the process of developing some shared governance functions such as human resources. We found the management structure was going through a period of change and the practice manager had just been recruited as patient services manager for the group. The senior managers we spoke with were clear about the plans and changes taking place although they had not developed a written structure at the time of the inspection, to clearly show all the new roles and functions.

We found the senior management team and staff continually looked to improve the service being offered. For example, they had extended the practice surgery space and utilised all the knowledge and skills offered by the clinicians across the group to enable them to offer more services to patients.

There was a clear leadership structure within the practice with named members of staff in lead roles. For example, one GP was the lead for safeguarding and another GP was the lead for information governance. Staff we spoke with understood their role and some were in the process of receiving training to enable them to take on new tasks as part of their changing roles. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns

Whilst the GPs and practice manager we spoke with had a clear vison for the practice and we could see there had been substantial investment in the practice, there was no business plan or development plan available. We also asked to see a financial review of the practice and a financial plan for the future but these were not available.

The practice had a number of policies and procedures in place to govern activity and these were available to staff.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with or above national standards and the practice had achieved almost maximum QOF points at 99.1%.

The practice had evidence of clinical audits which were used to monitor quality and to identify where action should be taken. The GPs clinical audits were often linked to medicines management information or as a result of information from incidents.

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

Leadership, openness and transparency

The staff told us there was a relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues.

The practice held regular staff meetings and the staff told us they met regularly as a group of practices and as an individual practice. They told us they felt it was beneficial to organise their meetings in this way. The staff told us there was an open culture within the practice. They said they had the opportunity and were happy to raise issues at team meetings. The staff also told us they had protected learning time and felt supported in their learning.

Patients could access a number of policies and procedures on the practice website and within the practice. For example, procedures relating to complaints, access to records, confidentiality and freedom of information were available. They also told us they had regular meetings and protected learning time.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received.

Are services well-led?

Good

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

The practice had a small patient reference group (PRG) which was established in May 2010. We spoke with three representatives of the group who told us there were approximately six members in the group and they aimed to meet every 3 months. They said meetings were chaired by the practice manager and minutes were forwarded to the PRG members, displayed on the PRG notice board and also on the practice website. The practice manager told us the practice had also set up a virtual group for patients who were unable to attend meetings, but were happy for the practice to contact them about the service via post, e-mail or telephone.

The PRG members told us they completed a practice survey annually and they visited the practice to speak to patients. The PRG had been involved in planning the annual surveys, reviewing the feedback and agreeing the action plan. They said the majority of comments on the last survey were positive. They said the practice had responded to any negative comments on the surveys and an action plan had been developed and implemented. For example, there was one negative comment about reception staff attitudes and this was discussed with staff at a protected learning time session. Comments about additional surgery time in the evenings resulted in increased GP evening sessions.

Staff feedback was gathered at regular practice meetings and through annual appraisals. Staff told us they felt comfortable approaching any of the management team.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had been able to develop their skills and knowledge.

The practice had completed reviews of significant events and other incidents and shared the information with staff at meetings to ensure the practice improved outcomes for patients. For example, significant events were reviewed during a weekly multidisciplinary meeting and non-clinical issues were discussed at the weekly staff meetings.